mental health digest

National Clearinghouse for Mental Health Information, Vol. 1, No. 7, July 1969

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cover story

A young child and his tutor put together a puzzle in an experiment designed to stimulate the culturally deprived. This experiment is part of current research supported by the National Institute of Mental Health. This study is adding evidence to the theory that lack of stimulation can contribute to mental retardation. Earl Schaefer, Ph.D., of the NIMH Center for Studies of Child and Family Mental Health, is collaborating with a Washington agency in a project involving disadvantaged infants aged 15 months to three years, using tutors on a one-to-one basis. Dr. Schaefer believes that stimulation of the child must start at about 15 months because there is mounting evidence of irreversible retardation which occurs before the child reaches school age. Requests for the article, "The Edge of Education", which appeared in the January-February 1969 *HSMHA World*, should be sent to the Office of Communications, NIMH, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

mental health digest

The *Mental Health Digest* is a monthly publication of the National Institute of Mental Health. Designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view, the *Digest* contains condensations of selected current journal articles, reviews, Federal and State program documents, and other pertinent material.

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Use of funds for printing this publication approved by the Director of the Bureau of the Budget, May 20, 1968.

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Systems Analysis and Mental Health Services

Bellenden R. Hutcheson and Elliott A. Krause

Out of research and program planning needs in science and social service fields and originating in operations research, a new profession has come into being: "systems analysis." The systems analyst and his research methods will be of major importance in the mental health field.

The systems analysis approach has several goals:

To decide on a mission or goal of a program.

To describe the boundaries of the system and its subsystems.

To ascertain the ways in which the system changes and the factors which produce the change.

To make a model which considers all elements of the system both as static and as functioning in time.

To use the model to produce theoretical changes of different types, to see what possible outcomes would result from each set of changes.

To pick out the most desirable outcome and do in reality the activities described in the model.

To cut costs, clarify problems, and avoid wasted time, by doing this experimental manipulation of models using time and cost variables and thus to consider the most practical and efficient course to follow in achieving the desired end, before one actually intervenes in the situation.

For mental health service, the goal of the systems analysis approach would be to promote the mental health of a given region by isolating relevant factors which can be manipulated favorably to change the environment, human and nonhuman. In mental health service, therefore, systems analysis may bring ecology—the interaction of people and their environment—into the area of ethology, the biological study of social behavior.

Mental health, especially community mental health planning, needs such a comprehensive approach. If mental health were as well-defined as moon rocketry, the application of systems analytical techniques would be less of a problem. The mental health service field is at the exploratory and program-planning stages in many community mental health programs.

Before we can proceed with the systems analysis technique we must "draw the boundaries," "assemble the data," and "narrow the choice down to the best solutions." The word *best* is important, for groups disagree over the goals. If the groups agree on broad goals, such as increasing happiness and decreasing pathology of neurotic, psychotic, and psychopathic sorts in the community, what pathways and programs are most useful? It would appear wise both to limit and broaden the research efforts and the problem, in order to gain the most from systems analysis techniques at this stage in their development.

The most important limitation appears to be that of geography and topography. If the first approaches are carried out on small islands or peninsular land areas of relatively homogeneous population, the number of variables and especially the boundary-drawing problem are partially solved, at least in terms of this community as a social system.

While the preliminary study should be limited geographically, it should not be limited to the "mental health service" orbit or to a study of the interrelations of the mental health or the

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health and the welfare subsystems. This would defeat the purpose of the systems approach, which must view all mental health agencies, staff, and clientele as part of and affected by many other subsystems in the overall society.

The nonhealth and welfare world must be included in the model—the family subsystem, the business organization subsystem, and the national socioeconomic environment. After the analysis of factors influencing change in the mental health area, we can tell what influences change in the mental health problems and in the quality of services rendered, and what is irrelevant. In our model of the interaction network, we must be all-inclusive to avoid the risk of missing the key factors because we naively assumed, a priori, that they were "irrelevant."

A final reason for narrowing the focus has to do with the complexity of trends in any region. For practical purposes, it will be helpful to isolate major local trends early, to observe their influence on mental illness and pathology. The more specific the locality, the clearer the choices for intervention will be for the mental health profession and the community as a whole.

There are two major types of systems analysis which have direct use in mental health service planning. Some models aim at direct depiction of environmental influences, and others focus on alternative outcomes for a given set of constraints. Specific techniques include input-output analysis, set theory, queuing theory, path analysis, and other mathematical approaches.

Two types of systems analysis techniques will be used here. The first we call the "raw interaction pattern" approach, and the second, the "one-index" approach.

Raw Interaction Approach

Let us consider a given small region, a part of a community, in terms of a set of social "sectors:"

I. Household Sector
   - Head of household
   - Children
   - Other adults

II. Nonprofit Organization Sector
   - Mental health agencies
   - Welfare agencies
   - Public health agencies
   - Hospitals and clinics (nonmental health)
   - Deviance control agencies
   - Governmental organizations
   - Political organizations
   - Social clubs and recreational groups

III. Profit Organization Sector
   - Business organizations in study region
   - Business organizations out of study region

IV. Overall Environmental Sector
   - Broader socioeconomic environmental factors (business cycles—national trends in socioeconomic area)
   - Physical environment of study region

It is possible to consider each sector as interacting with each other sector, and form a master table for social activities. Each of the sectors produces phenomena which affect each of the other sectors. Consider households. They contain, among many things, children and household heads. Household heads produce activity relevant to their own household, to nonprofit organizations such as hospitals and welfare organizations, to employing businesses, to the wider socioeconomic environment, since such phenomena as population growth and employment rates are in large part related to and caused by activities (or inactivities) of household heads. Similarly, children in households produce behavior of relevance to all the other sectors.

What would a "raw interaction pattern" analysis have as its goals and

uses? Such a matrix would act as an organizing device for the many different kinds of rates and statistics presently gathered on communities. It would act as a framework for organizing data on household size, usage of health agencies by households, employment rates, and so forth. This would be a way of examining a series of "social indicators" and seeing which vary along with which others in the community.

The "raw interaction pattern" approach has disadvantages from the point of view of a sophisticated systems analysis. It is a starting point to force the analyst to list and discover indices for the interaction of all possible sectors (and subsectors) of the community. But its disadvantage is that it cannot use the mathematical techniques of input-output analysis.

One-Index Approach, with Time as the Index

Time can be considered in various ways in science. We propose to use it as a measuring device. It is superior in comparability to almost any other index. If we take all sectors relevant to a specific community region and a limited period of time, we can see how each sector budgets its time with respect to each other sector. Taking all household heads in region X—let us call it "McKay's Peninsula"—we can see that these individuals budget their waking time among the other sectors. Suppose we take a survey of household heads and find the approximate distribution of hours spent by a random sample in this region.

This "time-allocation" analysis can be done for all the social bodies in each social sector—how does each sector budget its total "live time" or activity-time among the other sectors.

This is essentially a gigantic "time and motion" study of the overall community. Now, by use of mathematical models, it is possible to introduce changes in some part of the network, for example, in the amount of time householders spend in contact with nonprofit welfare agencies, and to estimate the consequences.

The next step could be to decide on goals or desired consequences which we would prefer if we altered some element in the system, i.e., some cell in the master table. Then we could try out different changes, to see which intervention came the closest to the ones which were sought.

"Time is Money"—The Cost-Accounting Problem and Systems Analysis

One problem in moon rocketry or mental health is limited funds.

Two kinds of changes could be introduced into the model. The costs for the changes could be figured after the alternative activity-pattern changes were calculated. It might be that change *A* and change *B* would have the same consequences for the time spent by one other sector—and no difference in money-costs, but the secondary consequences would differ for the two changes. The system analysis could show the time and dollar consequences of both approaches.

Modifying McKay's Peninsula

Using our hypothetical McKay's Peninsula, what steps must a professional group go through if it wants to modify the system and use systems analytical techniques to help in a program for change?

The next effort can be conceived of as modifying the time-allocation of activities of people in one sector to reach a decided-upon goal. If the mental health area is of concern, the next task is to decide on the desired

mental health mission, and to characterize this mission in terms of reallocation of time and costs. This agreement on goals may be a major task in itself. One method of achieving a consensus would be to use a balanced sample of practitioners, citizens, theoreticians, and administrators to arrive at a group goal. Then this can be translated into a new pattern of time and costs, using the systems models.

Evaluation of the success of the change effort is twofold. First, we can see whether the changes were accomplished to the extent of, and in the priority implied by, the stated goal of the professional and lay community. Second, if the goal is reached more completely by one professional group than by another, on the same problem and with the same time-costs, this will have major implications for service planning in the community.

The significance of the approach concerns the understanding of integration of mental health activities into the overall social-economic system. This approach refuses to treat either the mental health or the "nonmental" health variables separately, but studies the complexities of their inevitable interaction in the community.

This research will select and use indicators, not talk about them in a catalog fashion. This will be one of the first tests of the use of intercorrelated social indicators in understanding the social process in a given real metropolitan region. This type of systems research is important also because of its use of environmental data as factors built into the analysis of trends and interactions, rather than statically.

Studies of this type would be the first time, to our knowledge, that the sophisticated and important input-output model was used for analyzing general social trends and mental illness-related trends for a community.

Research of this type can be used as a testing ground for some of the most general ideas in social systems theory. Will we find a system of interchange in a community? If not, what will we find in the way of interchange networks? What degree of closeness or noncloseness of relation will we find?

The final major significant use of these techniques lies in their practical value to planners in community mental health.

Limitations of the Systems Analysis Method

The first problem is the completeness and accuracy of information relevant to the task. Gathering of information may be a primary research problem for the analyst, and a practical problem for the service staff in the community.

Goal-setting is a second major problem. What if the mental health professionals set up one set of goals and the community sets up another? The result will be a systems analysis which comes up with just what the "mental health establishment" wants, but which may be quite irrelevant to community need. Thus we suggest that citizen participation be built into the systems analysis process, at the stage of goal-setting.

A third problem is based on the experience with attempts to plan scientifically, using any form of systematic method. The expectations of the mental health professional and the community may be too great, considering the present state of the art of systems analysis. It is not a cure-all. One should not confuse a research and planning technique with a system of

moral values, a religion, or a universal panacea.

A fourth problem involves the issue of "economizing" in health areas. Techniques which analyze the distribution of time, resources, and professional activities are not "loyal" to any professional group. Nor do these techniques respect the usual status hierarchy of the service professions. Feelings may be hurt and antipathy generated against any research group which applies cost-effectiveness analysis to a service area. Or the technique can be perverted into a method for showing the cheapest way to provide service, which may not be the most advisable way to plan mental health services. If the goal is objectivity and increase in effectiveness of service, it should be possible to communicate this to the concerned service professions and gain their cooperation.

Finally, there is the problem of the time needed to carry on a comprehensive systems analysis. This could be called the problem of the harassed administrator. Systems analysis techniques are not the fastest way to get an answer. The fastest way is to make a "seat of the pants" judgment and fire away. Yet these judgments have turned out wrong as many times as they have been right and, once the decision is made, it is no longer possible to consider alternatives. The more important the plan, the longer the time with which it is concerned, and the more the administrator is interested in considering alternatives, the more relevant systems analysis techniques become. They do not produce quick and easy solutions, but they may add to the scope of the known in the mental health field—a field, like many others, full of puzzling unknowns.

Television and Psychiatry

RONALD S. REIVICH and ROBERT H. GEERTSMA

If behavior is to psychiatry as cell structure is to pathology, then it has been only for a short while that psychiatry has had a tool commensurate with the microscope. That tool is television. Observational media in psychiatry have come to play an important part in training programs and research. There is a chance that these media may prove to be significant in treatment.

"Observational media" subsumes all devices which afford enhanced capability for visualization and audition. In psychiatry these devices include one-way vision mirrors, sound transmission systems, closed circuit television, motion pictures, audio recording, and videotape. Only the latter three provide storage and retrieval capability via recording and playback. This capacity to replay behavioral processes endows observational media with special significance to psychiatry.

Psychiatric Training

Traditionally, psychiatry has been taught as every other medical specialty: seminars, readings, case conferences, ward rounds, and individual supervision of cases. Many educators have been aware of the weaknesses of these methods and have felt the need for modifications. Residents trained in a private hospital will not ordinarily see the kinds of psychopathology seen by residents at public institutions, and vice versa. Ward rounds are pointless on a psychiatric service. Consequently, most university departments have replaced rounds with patient-staff meetings.

Individual psychotherapy supervision may be criticized because the resident does not present a veridical picture of what actually transpires in his session with the patient, for he must depend on memory supplemented only by "process notes" jotted under the stress and demands of the interview itself; the supervisor does not see the resident actually perform psychotherapy, and the resident rarely observes an expert actually do psychotherapy.

The utilization of observational media to supplement or to replace traditional methods can overcome these problems. Electronic mediators can be used in three ways: for demonstration, for monitoring performance, and for self-observation.

For *demonstrating,* recordings of actual behavior can be collected and exchanged so that tapes are available, and residents in any kind of setting are exposed to a wide variety of patient-types and problems. At the University of Kansas Medical Center, visiting lecturers have been recorded for replay to students and other trainees. Closed circuit television and tape recordings have been used to present psychopathology and to demonstrate interviewing techniques, individual psychotherapy, group therapy, psychological testing, electroconvulsive treatment, and play therapy.

One popular and useful mode of teaching has been a continuing treatment seminar involving a senior therapist and a patient in treatment for two years. All sessions are observed by residents and clinical psychology interns on closed circuit television or by videotape recording. After each session, the therapist and students meet to discuss

Condensed with permission from the *Journal of the Kansas Medical Society,* 70(3):101–104, 1969.

the psychotherapy hour. This demonstration and teaching provide the student with a model of effective therapy on which he can base and assess his own therapy behavior, and can be considered a form of identification learning, an important mechanism for the learning (in effect, by imitation) of important social roles.

Monitoring by television or videotape provides the supervisor with the opportunity to evaluate directly a resident's performance. The supervisor can correct the resident's errors before they become ingrained and before they become detrimental to the patient. The resident can validate his diagnostic impression and psychodynamic formulations against those of his supervisor. And the supervisor can be reassured about the professional growth of the resident and the progress of the patient.

Self-observation enables the student to review his therapy sessions without the concomitant stress of having to interact with the patient. He can compare his performance with that of the model therapist whom he has observed on television. Often, the confrontation with a videotaped image precipitates shocked surprise, sometimes even a short-lived, dazed depression. Despite this early "stun" effect, students tend to be extremely enthusiastic about this mode of teaching. It is too early to evaluate how important this kind of learning experience will be in the student's overall professional growth. Much research needs to be done in this area.

Research and Treatment Applications

Although motion pictures have been used in behavioral studies, the high cost of film production has been a prohibitive factor. In the case of sound recording the absence of the visual dimension resulted in omission of significant behavioral data. The advent of low-cost videotape hardware has eliminated both these drawbacks.

Although some clinicians have begun to employ videotape playback as an aid to treatment, there is neither impressive theoretical reason nor empirical data to justify this use except as an experimental procedure. However, some findings do suggest the possibility of therapeutic application, but cautionary observations on the possible adverse effects of carelessly or thoughtlessly programmed self-confrontational experiences have been made.

The Concept of a Learning Laboratory

While observational media may or may not play a critical role in psychiatric treatment, they have already assumed an important role in training. Their role in psychiatry is somewhat analogous to their role in the speech and language fields. In speech therapy, a traditional speech modification technique involves having the subject listen to "correct" words, phrases, or sentences and then asking the subject to duplicate the sounds he has heard. Then the subject listens to a tape recording of his own speech so that he can compare and contrast it with the criterion. Teachers of foreign languages employ language laboratories where students listen to a criterion performance, attempt to imitate it, and obtain feedback via a replay of their own audiotaped endeavor. Can the concept of a speech or language laboratory for learning be applied to psychiatry? The systematic and parsimonious utilization of observational media must lead someday to development of a psychiatric analog of the language laboratory which can be used to supplement traditional conference room teaching.

Other kinds of technology have begun to reach psychiatric training programs. They are:

Programmed instruction, involving audiovisual material displayed on a console.

Single concept films, produced on 8-mm casettes for brief audiovisual presentations.

Interuniversity tape exchanges, which may entail a comprehensive formal network for cataloging, storing, and exchanging special educational tapes, films, instructional programs, etc.

A well-designed laboratory module, containing television production and playback equipment as well as projection apparatus to provide the tools required to enable students to utilize observational media optimally.

A Multifunctional Learning Unit

A learning laboratory in psychiatry must be flexible so that the expensive equipment can be fully utilized. The unit that we are planning consists of a central control area where a technician will be stationed. This area will have access to four contiguous interview and playback rooms. Adjacent to the control and playback areas will be a classroom and group therapy room equipped with versatile audiovisual aids.

In the central area will be television cameras, a control panel for electronic switching and amplification, and specialized cameras and circuitry for obtaining data storage and writeout capability. For example, several physiologic parameters on an oscilloscope could be time-locked to a recording of an interview so that physiological measures can be correlated with the behavioral events. The interview and playback areas will be set up as small offices with remote controls in easy reach of student, therapist, or supervisor. Operation of the videotape recorder and cameras will be simple and unburdensome, with minimum disruption of therapy or supervision.

When videotape self-observation procedures become an adjunct to treatment, the interview rooms, of course, can be used for that purpose. Medical students, psychology interns, residents, and staff can utilize the equipment for diverse purposes at varying levels of professional sophistication.

A Computerized Mental Status

EUGENE LASKA, GEORGE M. SIMPSON, and RHETA BANK

A questionnaire in conjunction with a computer program that can produce a narrative output can help the psychiatrist. Uniform data could be collected on optical scanning forms from psychiatrists practicing in hospitals, clinics, and other situations, stored in the computer system, and be easily and quickly retrieved.

A checklist-generated computer-produced narrative will not replace the subtle observations and graphic descriptions made by great clinicians. But great clinicians are rare. Although poetic prose may give a graphic image of a person, it gives few hard facts with which to compare him with someone else; and comparison is a vital part of psychiatric research.

Our mental status examination is a prototype form with widespread application. It consists of four sheets, with questions completed by marking the appropriate space. Information includes the patient's identification number, name of doctor, date of examination, sex and age of the patient. The form then follows a standardized mental status examination with description of the patient's appearance, physical health, body build, dress, facial expression, posture, and gait.

A rating scale is used for items such as general behavior and activity; affect; biological-vegetative phenomena including sleep disturbance, diurnal variation, loss of weight, loss of appetite and loss of energy; psychophysiological data; and speech activity including perseveration, circumstanneologisms.

Perceptocognitive phenomena such as derealization and depersonalization are included, followed by a section on thought processes with blank spaces where content of delusions, ideas of reference, or phobias are added. Evaluation of the sensorium, orientation, attention, memory, self-appraisal, responsibility, and sexual adaptation are included. An evaluation of intelligence, insight, judgment and a diagnosis complete the scale.

Embedded in the form are standard rating scales: a modified Hamilton rating scale for depression, the Wing rating scale for schizophrenic symptoms, and a portion of a scale based on Langfeldt's prognostic items for acute schizophrenia.

If physicians wish to add idiosyncratic material, this can be accomplished by typing and appending the material to the computer printout; it is also possible to have the items key punched and added directly to the printout by the computer.

Shown below are mental status reports produced from examination of a manic-depressive depressed patient who received imipramine. The first describes the patient at initial interview and the one four weeks later describes the patient in remission.

Condensed with permission from *Comprehensive Psychiatry*, 10(2):136–146, 1969.

MENTAL STATUS REPORT

PATIENT NO. 2
EXAMINING DOCTOR NO. 3
DATE OF EXAMINATION NOVEMBER 14, 1967

THE PATIENT IS A 42 YEAR OLD FEMALE WHO LOOKS HER AGE, APPEARS TO BE IN NORMAL PHYSICAL HEALTH, AND IS UNREMARKABLE IN BODY BUILD. SHE HAS NO PHYSICAL DEFORMITY. THE PATIENT'S POSTURE AND GAIT ARE UNREMARKABLE. THE FACIAL EXPRESSION OF THE PATIENT IS FRIGHTENED AND HER DRESS IS METICULOUS. OTHER BODY MOVEMENTS INCLUDE SLIGHT TREMOR.

HER GENERAL BEHAVIOR IS SLIGHTLY HISTRIONIC, MODERATELY OBSESSIVE, AND SLIGHTLY WITHDRAWN.

THE AFFECT IS ONE OF MODERATE ANXIETY, SLIGHT PERPLEXITY, SLIGHT FRIGHT, AND MODERATE DEPRESSION. THERE IS ASSOCIATED MARKED PESSIMISM ABOUT THE FUTURE, MODERATE SELF-REPROACH, MARKED NARROWNESS OF INTERESTS, MARKED INDECISION, MODERATE FEELINGS OF GUILT, AND SLIGHT SUICIDAL PRE-OCCUPATION. THERE ARE DIURNAL MOOD VARIATION SYMPTOMS WHICH ARE MILDLY WORSE IN THE MORNING.

THE PATIENT'S SLEEP PATTERN IS DISTURBED SEVERELY IN THE EARLY PART OF THE NIGHT, MODERATELY IN THE MIDDLE PART OF THE NIGHT, AND MILDLY IN THE LATTER PART OF THE NIGHT. THERE IS SOME LOSS OF APPETITE, MODERATE LOSS OF ENERGY, AND MILD LOSS OF WEIGHT. THE PATIENT HAS COMPLAINTS OF SEVERE DISTURBANCE IN SEXUAL ACTIVITY IN THE DIRECTION OF HYPOACTIVITY. SHE IS MODERATELY CONCERNED WITH CURRENT HEALTH. THERE ARE SPECIFIC SYMPTOMS OF MILD HEADACHES AND MODERATE CARDIOVASCULAR DISORDER. THERE IS MILD RETARDATION AND MODERATE OBSESSIONS/RUMINATIONS APPARENT IN THE THOUGHT PROCESS. CONTENT INCLUDES MODERATE PHOBIAS.

PERCEPTION IS NORMAL.

SENSORIUM IS CLEAR.

THERE IS FULL ORIENTATION.

ATTENTION-CONCENTRATION IS MILDLY IMPAIRED, MEMORY SHOWS MILD GENERAL IMPAIRMENT FOR RECENT EVENTS AND MILD GENERAL IMPAIRMENT FOR REMOTE EVENTS. INTELLIGENCE OF THE PATIENT IS ASSESSED AS ABOVE AVERAGE AND HER INSIGHT IS CONSIDERED TO BE ADEQUATE. JUDGEMENT IS NORMAL. THE PATIENT HAS MODERATE INFERIORITY FEELINGS.

THE PATIENT DISPLAYS LACK OF RESPONSIBILITY TO A MODERATE DEGREE IN FAMILY MATTERS AND TO A MODERATE DEGREE IN SOCIAL MATTERS.

HAMILTON RATING SCALE

ITEM	SCORE
1.DEPRESSED MOOD	2
2.GUILT-FEELINGS	2
3.SUICIDE	2
4.INSOMNIA EARLY	2
5.INSOMNIA MIDDLE	1
6.INSOMNIA LATE	1
7.ENERGY	3
8.RETARDATION	1
9.AGITATION	0
10.ANXIETY PSYCHIC	3
11.ANXIETY SOMATIC	1
12.APPETITE, ETC.	1
13.SOMATIC GENERAL	1
14.GENITAL SYMPTOMS	2
15.HYPOCHONDRIASIS	0
16.LOSS OF WEIGHT	1
17.INSIGHT	0
18.DIURNAL VARIATION AM	1
TOTAL	24

ACUTE SCHIZOPHRENIA

ITEM	SCORE
ITEMS 1,2,3 OF SCALE REQUIRE DATA FROM OTHER SOURCES.	
4.AFFECTIVE SYMPTOMS	0
5.COGNITIVE SYMPTOMS	1
6.PERCEPTUAL SYMPTOMS	0
7.POVERTY OF SPEECH	0
8.DELUSIONAL SYMPTOMS	0
TOTAL	01

WING RATING SCALE

ITEM	SCORE
1.FLATNESS OF AFFECT	1
2.POVERTY OF SPEECH	1
3.INCOHERENCE	1
4.COHERENT DELUSIONS	1
TOTAL	04

COMPUTERIZED MENTAL STATUS

MENTAL STATUS REPORT

PATIENT NO. 2
EXAMINING DOCTOR NO. 4
DATE OF EXAMINATION DECEMBER 11, 1967

THE PATIENT IS A 42 YEAR OLD FEMALE WHO LOOKS HER AGE. APPEARS TO BE IN EXCELLENT PHYSICAL HEALTH, AND IS UNREMARKABLE IN BODY BUILD. SHE HAS NO PHYSICAL DEFORMITY. THE PATIENT'S FACIAL EXPRESSION, POSTURE, GAIT AND BODY MOVEMENTS ARE UNREMARKABLE. HER DRESS IS METICULOUS.

HER GENERAL BEHAVIOR IS UNREMARKABLE.

THE AFFECT IS ONE OF MILD ANXIETY. THERE ARE DIURNAL MOOD VARIATION SYMPTOMS WHICH ARE MILDLY WORSE IN THE EVENING.

THERE IS NO DISTURBANCE OF SLEEP PATTERN. THERE IS NO LOSS OF APPETITE, NO LOSS OF ENERGY, AND NO LOSS OF WEIGHT. THE PATIENT HAS COMPLAINTS OF MILD DISTURBANCE IN SEXUAL ACTIVITY IN THE DIRECTION OF HYPOACTIVITY.

SHE IS NOT OVERLY CONCERNED WITH CURRENT HEALTH. THERE IS MILD OBSESSIONS/RUMINATIONS APPARENT IN THE THOUGHT PROCESS.

PERCEPTION IS NORMAL.

THE PATIENT IS DISTURBED TO A MILD DEGREE BY DEPERSONALIZATION EXPERIENCES.

SENSORIUM IS CLEAR.

THERE IS FULL ORIENTATION.

MEMORY IS NORMAL. INTELLIGENCE OF THE PATIENT IS ASSESSED AS AVERAGE AND HER INSIGHT IS CONSIDERED TO BE ADEQUATE. JUDGMENT IS NORMAL. THE PATIENT HAS MILD INFERIORITY FEELINGS.

THE PATIENT IS AWARE OF AND MEETS HER RESPONSIBILITIES.

HAMILTON RATING SCALE

ITEM	SCORE
1.DEPRESSED MOOD	0
2.GUILT-FEELINGS	0
3.SUICIDE	0
4.INSOMNIA EARLY	0
5.INSOMNIA MIDDLE	0
6.INSOMNIA LATE	0
7.ENERGY	0
8.RETARDATION	0
9.AGITATION	0
10.ANXIETY PSYCHIC	1
11.ANXIETY SOMATIC	0
12.APPETITE, ETC.	0
13.SOMATIC GENERAL	0
14.GENITAL SYMPTOMS	0
15.HYPOCHONDRIASIS	0
16.LOSS OF WEIGHT	0
17.INSIGHT	0
18.DIURNAL VARIATION PM	1
TOTAL	02

ACUTE SCHIZOPHRENIA

ITEM	SCORE
ITEMS 1,2,3 OF SCALE REQUIRE DATA FROM OTHER SOURCES.	
4.AFFECTIVE SYMPTOMS	0
5.COGNITIVE SYMPTOMS	0
6.PERCEPTUAL SYMPTOMS	0
7.POVERTY OF SPEECH	0
8.DELUSIONAL SYMPTOMS	0
TOTAL	00

WING RATING SCALE

ITEM	SCORE
1.FLATNESS OF AFFECT	1
2.POVERTY OF SPEECH	1
3.INCOHERENCE	1
4.COHERENT DELUSIONS	1
TOTAL	04

Three Alternatives to the Double-Blind

R. Plutchik, S. R. Platman, and R. R. Fieve

"Bias" as an experimental design concept may be defined as any cause, factor, variable, or suspected variable which could conceivably make the conclusions from an experiment invalid or render them ambiguous.

Possible sources of bias exist in all experiments. There is no way to create a completely bias-free experiment. What is important is that the distinction be made between important and trivial sources of bias and that the important ones be dealt with appropriately.

In the study of drug effects, a source of bias is the psychiatrist's attitudes, expectations, or personal commitments in relation to belief or lack of belief in the efficacy of a drug. Investigators who are enthusiastic about a drug usually report better results than are obtained by skeptical investigators. This kind of variable has been reported to operate in a wide range of academic and laboratory settings.

Most investigators concerned with drug research seem to have come to the conclusion that the way to deal with these biases is to use a double-blind method, i.e., the experiment is set up in such a way that the patients do not know which medication they receive and the psychiatrists do not know which medication the patients are on. This double-blind method has been criticized on several grounds.

Drugs produce side effects which are easily noticed by the evaluating psychiatrist. A second argument is that it creates a highly artificial situation which has little relevance to the clinical setting in which any drug would actually be used. There are some situations where the technique cannot be used, e.g., if electroconvulsive therapy is being compared with an antidepressant drug, it is impossible to keep this information blind to either the patient or the psychiatrist. Occasionally, ethical considerations preclude the use of the double-blind approach. In a comparison of imipramine and lithium for manic-depressive patients, the medications could not be assigned at random since some patients were manic or hypomanic at the start of the trial and some were depressed. Finally, even when the double-blind approach can use random selection and blind assessment, it does not guarantee unequivocal results. For example, use of fixed doses may underrate the value of the drug. Similarly, if drugs with different time-courses of effect are compared, the differences between the two drugs may be overgeneralized in favor of one of them.

This does not mean that the technique should be abandoned or that the goal of identifying "true" drug effects must be renounced. There are situations where the double-blind is the method of choice. There are other situations where it cannot be used. In such cases, there are at least three other ways of dealing with expectations as sources of bias.

Alternative Approaches

In general, sources of bias can be dealt with in four ways: by eliminating them (as in the double-blind method), by measuring them, by distributing them, and by exaggerating them.

Eliminating bias—The double-blind technique was developed for elimi-

Condensed with permission from the *Archives of General Psychiatry*, 20(4):428–432, 1969.

nating bias. It assumes that a psychiatrist's expectations about a particular drug cannot operate if he does not know which drug he is evaluating. The double-blind is usually inadequate when side effects of the drug reveal its nature.

Two approaches have been suggested to deal with this problem. The first is to use a placebo which is believed to have no psychiatric efficacy but which does mimic some of the side effects of the drug being tested. This method has three drawbacks: It is almost impossible to mimic all the side effects, the method cannot be applied when two or more active drugs are being compared, and use of an active placebo may increase the number of placebo responders.

The other suggestion is to use doses which produce little or no side effects. The problem here is that drug efficacy is related to dose level.

Measuring bias—In the physical sciences it is recognized that measuring instruments are inaccurate to some degree and that the inaccuracy depends on the part of the scale that is being used for the measurement. This problem is dealt with by measuring the extent of inaccuracy associated with the measuring instrument and then specifying a tolerance range within which the "true" value of the measurement probably falls.

In psychiatric research, the instrument is often the psychiatrist himself. If it is believed that his expectations of the effect of a particular drug are biased, then a measurement of the extent of these biases must be attempted. This could be done in several ways.

One would require the psychiatrist-judge to indicate on a questionnaire or scale how strongly he believes in the value of the drug being tested. Another method would be to have a second observer rate the attitude of the psychiatrist who is judging drug value.

Both methods have limitations. The rating scale is easily falsified or subject to denials. The use of an outside observer creates still another problem, that is, an infinite regress. These comments imply that the measurement of observer bias is not an easy or simple matter.

Distributing bias—A procedure used to deal with bias is to try to distribute the bias equally over all conditions. This comes up frequently in situations wherein a practice effect exists so that observations made late in a series are different from those made early. Usually some kind of counterbalancing procedure is used to deal with this problem.

There are two ways in which biases may be distributed. One way is to use psychiatrist-observers who have opposite biases about the drug under consideration. The other approach concerns the patients. Two groups of patients should be used, the first consisting of patients who feel hopeful and enthusiastic about the possible effects of the drug and the second consisting of patients who feel hopeless and pessimistic about its effects.

One problem with both methods is that the degree of positive or negative expectations should be equal, a condition which is difficult to fulfill in practice. Another problem is getting psychiatrists who strongly differ about the effects of a drug to work together as part of a team. Distributing bias in a drug study is not easy.

Exaggerating bias—Sometimes in engineering, a factor is suspected as a source of uncontrolled variation. One way of dealing with such a suspected variable is to give it a value

much larger than it might normally have, and to determine how much of an effect this has on the phenomenon being measured.

If this idea is translated to drug research, the implication is obvious: create a situation in which the expectations are as strong as can be made. Patients should be told about the beneficial effects of the drug and be led to believe that it will help them considerably. Psychiatrists who believe in the value of the drug should be used as observers. Under these conditions the maximum benefits of the drug plus environment will be seen.

To evaluate this maximum effect, comparison is necessary. For example, the improvement rate could be compared with that which clinicians have come to expect with the particular drug under consideration. Or, in the case of a new drug, the improvement rate could be compared with that which would be found if an opposite bias were created. Such a negative bias would be obtained by selecting the most pessimistic patients and the psychiatrists with the most negative attitudes toward the drug in question.

The problem with this approach is that it does not enable an unequivocal evaluation of the magnitude of the bias effect since no baseline is present from which to measure. The method simply gives some outside limits of expected benefit from the drug in a highly favorable or unfavorable environment.

A further point needs emphasis. The extent of attitudinal biases in drug research depends to a considerable degree on the structure associated with the evaluation setting. If drug evaluations are made on a simple improved-unimproved scale on the basis of a relatively unstructured interview, there is opportunity for biases to influence strongly the conclusions. If the evaluations are made on standardized rating scales, using structured clinical interviews and independent observers, biases are much less likely to operate. If ward-behavior as well as self-report data are added to the evaluating procedure, the biases are not likely to be very influential. This implies that even so-called "open" studies may be reasonably satisfactory if information is obtained from multiple sources in highly structured ways.

Behavior Therapy and Behavior Modification

J. D. KEEHN and C. D. WEBSTER

There does not seem to be a clear differentiation between the procedures known as behavior therapy and the operant conditioning methods by which behavior modification is achieved. Both derive from behavioristic orientations, but the appearance of similarity is deceptive.

Assumptions underlying behavior therapy are: symptoms are evidence of faulty learning; treatment of neurotic disorders is concerned with habits existing at present; interpretation is irrelevant; personal relations are not essential for cures for neurotic disorders; cures are achieved by treating the symptom itself.

None of these statements applies unreservedly to behavior modification by operant techniques. According to principles of operant conditioning, faulty learning is impossible because the laws of learning are not at fault. Reinforcement simply asserts that behavior followed by a reinforcing state of affairs increases in strength. The strengthened behavior may be faulty so far as some independent standard of judgment is concerned, but this is not the result of faulty learning but of unfortunate response-reinforcement contiguities.

Paradigms for the two techniques have been labelled S-O-R (stimulus-organism-response) and S-R-S^R (stimulus-response-reinforcement); the former provides the context for behavior therapy, the latter for behavior modification.

Condensed with permission from the *Canadian Psychologist*, 10(1):68–73, 1969.

The S-O-R Paradigm

The assumption that behavior is the result of mental activity may be symbolized $R=f(O)$, meaning that behavior (R) is a function of events occurring inside the organism (O). This approach has been called a "self-action" approach.

Such action-type explanations of behavior are incomplete. A person who sunbathes naked in his garden would be unlikely to do so in a public park. The difference between the two decisions must take account of the difference between the situations, and the functional equation would be $R=f(O,S)$, i.e., behavior (R) is a function of situational (S) as well as organismic (O) variables.

The paradigm which encompasses these views may be written S-O-R to express the belief that the content of the mind (O) is provided by the organism's physical surroundings (S) and that this content, along with certain powers of the mind, determines the quality of behavior (R).

Many behavior patterns, like those described as psychotic, neurotic, schizophrenic, and hysteric do not appear to be dictated by free will and reason. They are regarded as mental illnesses with the implication that the behavior is less than ideal.

In these cases two assumptions have been made. The first is that the normal standard of behavior against which imperfect behavior is assessed is governed by a freely acting rational will. The second is that uncontrollable or irrational behavior is "nonlawful." Rejection of this second assumption by Freud led to the S-O-R paradigm. Freud assumed that all psychological phenomena are lawful. The theory he

constructed extended the power of S-O-R psychology but it did not revise it in principle. Psychoanalytic explanations are interaction-type explanations within the S-O-R paradigm with the topography of mentality extended to include an unconscious as well as a conscious mental apparatus.

Freud did not explicitly deny the relevance of consciousness in the analysis of behavior, but Watson, whose most influential follower was Hull, did. In Hull's system, as in Freud's, behavior serves only to exemplify the activities of internal structures and functions. Behavior therapy derives directly from Hull's theory of behavior and, like it, sits within the compass of S-O-R psychology.

The S-R-S^R Paradigm

Behavior modification belongs in a different paradigm made possible by Thorndike's formulation of the law of effect. The law was utilized by Hull to give substance to his program within the S-O-R framework and by Skinner in a way that effected a paradigm change. He acknowledged that behavior is controlled by its consequences —a more general formulation of the law of effect—and formulated the principles of behavior in terms of stimuli, responses, and effects (reinforcements) alone.

It is through response-reinforcement contingencies that control of behavior is acquired. Responses reinforced in one stimulus matrix but not in another continue to be emitted in the first case, but not in the second. The stimulus control of emitted behavior is attained by differential reinforcement. The paradigm may be written S-R-S^R —behavior (R) which is reinforced (S^R) in the presence of a stimulus (S) will be emitted in predictable fashion whenever that stimulus appears. The organism is not disregarded, for it is an organism that behaves and its behavior that is reinforced. But the focus of attention is on the relation between the organism's behavior and its environment, not on events allegedly occurring inside the organism's skin.

Explanation in the S-R-SR^R paradigm is transactional. A transaction-type explanation could be symbolized $R_A = f(R_B) = f(R_A)$, meaning that the behavior of person A is a function of that of person B which is a function of the behavior of A, and so on. The S-O-R paradigm assumes that an organism can be considered as a behaving entity independent of its environment, and that it can exist in a state, regardless of what environmental contingencies might prevail. The transactional attitude of S-R-S^R psychology does not regard organisms as isolatable entities but as "beings-in the-world," to use the existentialists' phrase. The former claims to know how to cure a patient with techniques that affect a change within himself; the latter claims to know how to modify behavior of an individual by controlling the transaction between himself and his surroundings.

Marriage and the Family in Modern Science Fiction

WILLIAM F. KENKEL

Why did I choose the subject "Marriage and the Family in Modern Science Fiction"? First I wanted to reinforce the notion that imagination, innovation, and creativity are prerequisites for all who work on marriage and the family. Second I wanted to talk about the future of marriage and the family. I am not construing this material as predictions of what *will* happen but as descriptions of what *could* happen.

I looked at some 225 stories and books. Many had little or nothing to say about marriage and the family. The remainder I organized in such categories as the childbearing function of the family, socialization function, and marriage and relationships between the sexes.

The Childbearing Function

Most of us accept the fact that neither our own nor any species can multiply indefinitely without facing the realities of a limited environment.

What do science fiction writers see? My readings disclosed two contradictory assumptions. One was that the world was not able to solve its population problems. Ten, twelve, or more billions inhabited the globe with horrendous results. The second saw the earth as uncrowded, but usually the means was left unstated. When it was spelled out, it was not pleasant to contemplate.

Some writers did not see an overpopulated planet resulting only from man's inability to control his reproduction but also his quest for longevity.

"To Open the Sky" (Robert Silverberg, New York: Ballantine Books, 1967) depicts life in 2077. By the time birth control was effective, there were ten billion people. Death control was getting better and human society was getting worse. The masses find escape with exotic, nonaddictive, hallucinatory drugs. Weird cults flourish and fads abound such as grafting of precious stones in the flesh and surgical removal of the eyelids.

In another story, (John Christopher, "Winter Boy—Summer Girl," Great Science Fiction, No. 7, 1967, pp. 83–94) man dealt with his population pressures by hibernating. A group of "winter watchers" took care of things including the cubicles wherein the summer people were asleep.

My feeling is that the predictions of an overcrowded planet are not too far off base unless, of course, a "self-defeating prophecy" comes into play.

We need to give more attention to some basic questions such as, "To whom does the Earth belong?" The assumption that man is the exclusive landlord of the planet has led to thinking in terms of maximum population sizes instead of optimum. Concepts such as "optimum population size" and the "good life" are not impossible to define and operationalize.

Our population pressures can be traced to some basic assumptions and concepts. "Responsible parenthood" first had a strong economic emphasis. Then it was enlarged to include ability of parents to meet emotional needs of children and to provide a good social environment. Now it has been enlarged to include responsibility for determining the impact on the population today and in the future. More rare still is a concept that takes into account the optimum size of population, either for the present or the future.

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I am in sympathy with programs trying to help those who have more children than they can "support" economically and emotionally. But by concentrating on these groups and failing to stress responsibility for future generations, we are assuring that we will have severe population problems.

A book dealing with the reproductive function is "The Virgin Planet" (Paul Anderson, New York: Avalon Books, 1959). A space ship manned by women lands in another solar system. The scientists develop a parthenogenesis machine, first for settlers and later for their descendants. Each child is a girl and inherits the physical features and personal disposition of her mother. Sex education is woefully inadequate. Adults withhold the facts of life from those who have not crossed the Holy River to the parthenogenesis machine. Children are taught about normal reproduction, memorizing that "man is the male of the species." Then a male explorer lands. He is told to prove he is male by immediately and publicly impregnating the maiden population. Despite the doctor-scientists who control the parthenogenesis machine, the women decide they would prefer real men and help the explorer return, with the promise that spaceships loaded with males will be dispatched to the Virgin Planet.

The most distressing story was "The Marching Morons" (C.M. Kornbluth, in Spectrum IV, ed. by Kingsley Amis and Robert Conquest, New York: Harcourt, Brace and World, 1965). Several generations before the timing of the story, geneticists realized that the masses could not be convinced to control their reproduction and recruited for a closed corporation to maintain and improve the breed. The three million descendants of the intellectual elite are slaves of the five billion morons. The moronic masses do not work much or for long hours but engage in sensuous pleasures at a crude level. The intelligent minority is overworked. Television is very popular. The morons love their automobiles which they believe travel at fantastic speeds. Despite a sleek appearance and dramatic sound effects, the cars have a speed of only 25–30 miles an hour, the highest the drivers can handle.

All this is science fiction. But today there is a rough direct relationship between the skill and training required for a job and the number of hours the incumbent is required to work. And speedometers on our cars have dials showing a maximum speed of 20–30 miles an hour faster than the cars can travel.

The Socialization Function of the Family

The writers did not seem to deal much with the socialization function.

In one story (Frederick Pohl, "The Man Who Ate the World," Galaxy Magazine, November 1956), it was recognized that childhood experiences could have an effect on adult personality. A boy, despite his plethora of toys, stole into his sister's room and took her robot teddy bear because it reminded him of one he previously had. The boy was punished because he had not learned the proper attitude toward consumer goods. One could not hold on to prized objects; things were to be used up, destroyed. As an adult, the boy became a compulsive consumer going beyond what was required of normal adults.

In another story (Philip K. Dick, "The Father Thing," in A Treasury of Great Science Fiction, ed. by Anthony Boucher, Garden City, New York: Doubleday and Company, 1959, pp. 245–254), a boy discovered that unbeknownst to his mother an alien creature had destroyed his father and taken possession of his body. The "father thing" looked and acted like the real father. The Oedipus situation was handled when the boy killed the "father thing." Killing his father but not killing him was the psychological equivalent of eating one's cake and having it. The boy felt no remorse, but righteousness.

More gentle parent-child emotions were described in "The Donor" (James E. Gunn, The Most Thrilling Science Fiction, 1966, pp. 3–30). This concerned a man who was born with an immunity factor which would repel cellular degeneration. He passed this trait on to a daughter. If the blood of the man or his daughter were received by anyone, it would give that person recuperative powers and immunity from death for 30–40 days. A trust was formed to lock up the daughter, bleed her for the benefit of the elite, and force her to breed additional donors. The father infiltrated the organization in the hopes of rescuing his

daughter. The father was thus devoting his immortal life to the protection of his daughter.

In "The Big Trip Up Yonder." (Kurt Vonnegut, Jr., in Assignment in Tomorrow, ed. by Frederick Pohl, New York, 1954, pp. 123–138.) the earth had a population of some twelve billion. The older people, the antigerasone generation, were in authority, controlling the entire society as well as their multigeneration apartments. Man had returned to the extended family ruled by an experienced, authoritarian patriarch.

As our birth rate drops and the proportion of people over 65 increases, we may wonder about the social and psychological effects of the demographic trends. Smaller families will mean that a larger proportion of children born will be first children who, it appears, are more conservative and traditional than later children. With more older people and with conservative young people, we may come to long for the dynamic generation gap with its challenge of the status quo and insistence that the ills of one generation do not have to be transmitted to the next.

Some writers had more gruesome ways than "antigerasone" for prolonging life. "A Planet Named Shayol" (Cordwainer Smith, Galaxy Magazine, 1961) tells of a planet where prisoners are sent to grow human body parts on themselves, which parts are shipped to other planets for replacements. The prisoners are offered the opportunity of having their optic nerves severed and are doped with tranquilizers.

Again, this is fiction. Surely man would not snatch body parts from another human, at least not until the donor was decently dead. But when does death occur? Before we have a satisfactory answer to "When does life begin?" we must deal with "When does life end?" I sense that we are drifting toward medicolegal definitions, arbitrary definitions by a panel of experts. Thus one panel can decide that a fetus is not sufficiently alive to continue living if the womb that nourishes it belongs to a woman who is too young, unmarried, biologically related to the child's father, or merely poor. Meanwhile, another panel could decide that a person was sufficiently dead so that his heart could be removed with impunity. The cartoon of the bum on the park bench with the sign "Just sleeping, not a heart donor," may not be as sick as we would like to think.

There are no easy ways to determine what constitutes proper human respect and reverence for life. Family specialists who should, I think, have something to say about basic human values seem to prefer silence to the risk of exposing their thoughts, particularly if their views are in the direction of a conservative position on respect for life.

Love and Marriage

What do writers have to say about love, marriage, and relationships between the sexes? Some assumed that questions of the equality of the sexes would be rational and amiable.

One writer (Robert Bloch, "The World Timer," The Most Thrilling Science Fiction, 1966, pp. 77–101) had a system involving three marriages. For the male the first was to satisfy sexual urges, the second for reproduction, and the third for companionship. The order was altered for women so that their first was for children and the second for sexual enjoyment. Since the sexes experience the height of sexual drive at different times, a young man about 16 would marry a woman of 28–40. At about age 26 the male would marry a girl about 16. During this marriage, the couple would have a few children, rear and lavish them with affection until they were six years old, and turn them over to the state. When men and women reached age 40, they would again change partners, this time emphasizing companionship, mutual tastes, and shared interests. The writer saw many advantages in the system. A young man could prove his masculinity in a direct, biological way when his sex drive

was at its height. He could spend his time on socially useful activities instead of trying to prove his manhood at football, juvenile delinquency, or use of alcohol or drugs. Anxiety over masculinity and homosexuality would be reduced.

This writer has a message for us. It is simply to work with man's biological nature, not against it. Research directed at discovering the benefits of youthful marriage would be a case in point. It might be discovered that chronological age at marriage has nothing much to do with successful marriage.

There are many ways in which we could better work with human nature than against it. This requires that we have adequate knowledge about human nature and that we strive to expand our understandings. There are some who seem to be saying that sexuality is the one important characteristic of a human and that sex education is all that is necessary to produce healthy adults capable of forming successful marriages. I have never seen such an extreme statement, but I have gathered something close to these sentiments. I believe that we will learn that an extreme emphasis on sexuality is working against human nature and that more than mature sexuality is needed for good marriages and families.

It is difficult to summarize and evaluate my explorations. One feature was the dearth of references to marriage and the family. This could mean that marriage and the family as we know them are about the best that we can expect. Or it may be because marriage and the family are not important enough to attract the imaginative attention of science fiction writers. It could be that most science fiction writers consider marriage and the family too sacred to tamper with or to alter radically; perhaps science fiction writers are themselves quite culture-bound. A technologically oriented society produces technological dreamers and dreams.

When science fiction writers did deal with marriage and the family, the results were caricatures of present-day problems. It was unpleasant to see our social foibles "writ large," whether the author was describing a completely materialistic world with almost ludicrous emphasis on consumption, a vastly overcrowded planet, or the crude tastes of the masses.

It was interesting to see in science fiction a blend of science and action. Scientists were not afraid to deal with real problems that beset their societies. There was no longer a debate over the relative importance of scientific research and action application of science, but a commingling of the two types of endeavors.

Territorial Defense and the Good Neighbor

Robert Sommer and Franklin D. Becker

The concept of human territoriality is receiving increased attention. When the term is used to refer to human behavior, there is no implication that the underlying mechanisms are identical to those described in animal research.

During observations of library study halls the concentration of readers at the end chairs was noted. There were two styles to gain privacy. One was to sit as far away from other people as one could. The other was ownership of the entire area. To study the two methods, a questionnaire was constructed which presented the student with table diagrams containing four, six, and ten chairs. Two forms of the questionnaire were distributed to 45 students. Twenty-four received "avoidance" instructions: "If you wanted to be as far as possible from other people, where would you sit?" Twenty-one were given the "offensive display" instruction: "If you wanted the table to yourself, where would you sit to discourage anyone else from occupying it?" Students who wanted to sit by themselves chose the *end* chairs; those who wanted to keep other people away chose the *middle* chair.

The present study involved four diagrams.

Form G showed eight rectangular six-chair tables, with a large aisle down the center and two smaller aisles along the walls.

Form H was the same except the tables were set against the wall and the center aisle was wider.

Form J had the right row of tables against the wall and the left row away from the wall.

Form I contained one row of four-chair tables and one row of eight-chair tables, with aisles in the center and along both walls.

Four sets of instructions were used; any single subject received only one set. One form asked where he would sit if he wanted to be by himself (retreat instructions), the other where he would sit if he wanted to keep people away (defense instructions). On half the questionnaires, it was stated that few people would be using the room, while remaining subjects were told that many people would be using the room. All instructions described the room as a study hall and the respondent was informed that he was the first occupant. During the retreat conditions 76 percent occupied a wall chair compared to 48 percent during the defense condition.

The data disclose a preference for a subject to sit with his back to the door. But 44 percent in the defense condition faced the door compared to 36 percent in the retreat condition. In all conditions there was a preference for chairs toward the rear. Occupancy of the rear was higher with the retreat instructions under high room density than in any of the other conditions. There was also a preference for the four-chair tables when they were paired with the eight-chair tables.

At this point we used an experimental approach under natural conditions. Since humans rely on visual markers, we tested the strength of markers ranging from the physical presence of a person to impersonal artifacts.

One study took place in a soda fountain where patrons obtain refreshments at a counter and then go to a small room to eat and chat. One room

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with three square tables, each with four chairs, was used. A girl who appeared to be studying was stationed at a table facing the door. A session took place only when the room was unoccupied at the outset. During only one of 10 sessions could she keep the room to herself. But she was able to protect her table. Territorial defense in a public area is not an all-or-none affair. The defender's presence may be seen in a delay in occupancy rather than an absence of invaders and in the avoidance of a subarea within the larger area.

The next study took place in an open-plan soda fountain, and three objects were used as markers—a sandwich wrapped in cellophane, a sweater draped over a chair, and two books stacked on the table. The experimenter located two adjacent empty tables and placed a marker on one with the other as a control. The sessions took place at moderate room density. There were eight sessions with a sandwich marker, 13 with a sweater, and 20 with the books. Markers were able to protect the particular chair almost totally, delay occupancy of the entire table, and divert groups away from the table.

A study using books and newspapers as markers was undertaken in a dormitory study hall at a time of light room density. All markers proved effective. One qualification is that the object must be perceived as a marker and not as something discarded by its former owner. Old newspapers or magazines may, indeed, attract people to a location.

The study was switched to a library periodical room where pressure for seats was great. The markers included two notebooks and a textbook, four journals in a neat stack, four journals scattered on the table, a jacket draped over the chair, and a jacket draped over the chair in addition to the notebooks on the table. Personal markers, such as the jacket and notebooks, kept away intruders entirely, while the impersonal journals only delayed occupancy of the marked chairs. More students who sat down despite the markers were males. Some sort of dominance or risk-taking factor may be at work in the decision to disregard a territorial marker.

Another finding concerns a neighbor's role. In all trials with the scattered journals, the potential invader questioned the person sitting beside the marked chair as to whether the space was vacant. At first the neighbor informed intruders that the space was taken. But as time passed, he would say, "Yes, somebody was sitting there, but maybe he's not coming back."

Since the neighbor's role seemed important, we investigated it. The first study involved two experimenters and a person sitting beside an empty chair. An experimenter seated himself next to a stranger (the neighbor) and then departed, leaving an open book and notebook. Then the second experimenter inquired about the marked space nonverbally. The nonverbal questioning included catching the neighbor's eye, pulling out the chair slightly, hesitating, looking at the markers and at the neighbor, and then back at the markers. In only six of 55 trials did the neighbor respond to the nonverbal gestures in a space-defending manner.

We next tried to see if the neighbor would defend marked space without being questioned directly. The experimenter sat down on the same side of the table, one seat away. In one condition the experimenter sat five minutes and then departed, leaving her books neatly stacked on the table. In

another condition, the experimenter asked the neighbor, "What time is it?" In the third condition, the experimenter spoke with the neighbor four times and, when leaving said, "See you later." In no trials did the neighbor inform the intruder that the seat was taken. So we strengthened the conditions by having the "owner" return and confront the intruder. Despite a usurpation of a marked space, all neighbors chose to remain uninvolved.

The next study employed two experimenters and the paperback books as markers. The neighbor was questioned directly as to whether the seat was taken. A total of 22 of the 38 neighbors defended the seat when questioned. However, the amount of contact between the experimenter and the neighbor made little difference in defensive behavior.

The final study employed two experimenters and the paperback books. The first experimenter again sat down on the same side of the table with a subject, leaving an empty chair between them. He remained either five or 20 minutes, and then departed, leaving a neat stack of books. After an interval of either 15 or 60 minutes, the second experimenter entered the room and asked the neighbor whether the marked chair was taken. The length of time that the first experimenter had occupied the chair had no effect on the willingness of the neighbor to defend the chair, but when he had been absent 15 minutes, 80 percent of the neighbors defended the space compared to 54 percent defending it after a full hour.

After the experiments 15 students were interviewed on the question of how personal belongings could reserve space. Although the majority said that they would protect a marked chair, in the actual situation no one had done so unless approached directly. The ethic regarding space ownership in the library exists, but is paid lip service, probably because institutional means of enforcement do not exist.

Generally it is geographers and lawyers who are concerned with boundaries and markers. Since our studies took place in public spaces, we are dealing more with norms and customs than with legal statutes. People are now spending much time in public or institutional spaces—theaters, airports, buses, schools, and hospitals—where the use of personal belongings to mark out temporary territories is common.

These studies suggest that investigation of spatial markers is feasible and warranted. The time is past when we can have theories of man that do not take into account his surroundings. Markers not only define what belongs to a person and what belongs to his neighbor, but who he is and what it means to be a neighbor in a complex society.

Alcohol and Recall: State-Dependent Effects in Man

Donald W. Goodwin, Barbara Powell, David Bremer, Haskel Hoine, and John Stern

Animals trained in a drugged state may "remember" better if tested in a comparable drugged state. Learning acquired in a nondrugged state transfers better to the same state. This "dissociation of learning" has been demonstrated primarily with anesthetic agents.

In studying this phenomenon we used a higher dosage of alcohol than was previously used and a wider range of learning tasks.

Forty-eight students, paid to participate in a training session (day 1) and a testing session (day 2), separated by 24 hours, were randomly assigned to four groups of 12 subjects each. One group (SS) was sober both days. A second group (AA) was intoxicated both days. A third group (AS) was intoxicated on day 1 and sober on day 2. The fourth group (SA) was sober on day 1 and intoxicated on day 2. Intoxicated subjects consumed between 8 and 10 ounces of 80-proof vodka, diluted in a soft drink, over 1 hour, after which testing began. Equivalent amounts of soft drink were given to nondrinkers.

Tests included an avoidance task to measure interference and latency of response, a verbal rote-learning task to measure recall, a word-association test to measure recall of "self-generated" learning, and a picture task to measure recognition.

On day 1 performance was significantly better in the SS and SA groups than in the AA and AS for both avoidance and rote learning—the expected depressant effect of alcohol.

In the avoidance task, compared to subjects remaining in the same state those in changed states made significantly fewer errors (were subject to less interference from original learning).

In both rote-learning and word-association tasks, the interaction effect was largely due to the fact that the AS group made significantly more recall errors than the AA or SS groups. In neither task did the SA group differ significantly from the same-state groups, although in both tasks the SA group made more errors than the SS group.

Latency of response in the avoidance task was not influenced by state change. Nor was there a significant interaction effect in the picture-recognition task, although in the case of "emotional" pictures, a trend toward dissociation was evident.

That drinking may facilitate recall of experiences which occurred while previously drinking has support from clinical observations. Alcoholics frequently report hiding liquor or money while drinking with no recall of the event until intoxicated again. They also report difficulty in spontaneously recalling events that happened during a drinking episode and having a return of memory when told about the event. This suggests that the memory deficit associated with changed state may reflect an impairment of retrieval rather than of registration and retention.

Condensed with permission from *Science*, 163(No. 3874):1358–1360, 1969.

The Effect of Reserpine and Monoamine Oxidase Inhibitors on Paradoxical Sleep in the Monkey

MARTIN REITE, G. VERNON PEGRAM, L. MICHAEL STEPHENS, EDWARD C. BIXLER, and OLIVER L. LEWIS

This study was undertaken to determine the effect of reserpine and MAO inhibitors on sleep in the monkey Macaca mulatta, a species whose sleep patterns are quite close to those of man and in which the distribution of biogenic amines in the brain is similar to man.

Three Macaca mulatta (Rhesus) monkeys were implanted with skull screws for EEG recording, screws for recording eye movement (EOG), and stainless steel or gold wire electrodes in the nuchal musculature for recording EMG. Each animal served as its own control. Following 4-5 all-night baseline recordings, the animals were administered parenteral reserpine (0.25 mg/kg), iproniazid (50 mg/kg), or tranylcypromine (2 mg/kg) in a counterbalanced design for seven consecutive days.

All three animals received reserpine and tranylcypromine; two received iproniazid in addition. All drugs were administered at 1200 hours. Recording started at 2200 hours and continued until 0700 the following morning. The animals were not permitted to sleep during the day. On the basis of the EEG, EOG, and EMG records, sleep was divided on a minute-to-minute basis into awake, non-REM sleep (drowsy, Stages II, III, and IV), and REM or paradoxical sleep. Total sleep time consisted of both REM and non-REM sleep. In addition, the following variables were computed: average number of REM periods per night, average REM period length, percent REM of total sleep, and REM latency.

The baseline sleep patterns for the control nights were similar for the three animals, resembling other descriptions of normal sleep in this species. Likewise, the drug effects were similar; accordingly, the various drugs will be considered individually in terms of their effects on all three animals combined, instead of by considering the animals individually.

Reserpine—Reserpine did not influence total sleep time or awake time. Total REM time in minutes and REM percentage were significantly increased. The length of the average REM period (in minutes) increased as did the average number of REM periods occurring during the night. The latency from sleep onset to the first REM period decreased. These effects were noted on the first night and continued throughout the drug administration.

Tranylcypromine—Tranylcypromine did not alter total sleep time or awake time. Although latency to REM onset increased markedly, neither total REM time in minutes nor REM percentage were greatly reduced. With a longer REM onset latency, once REM periods began they occurred with greater than normal frequency. Increased latency to REM onset was noted the first day and continued throughout drug administration.

Iproniazid—Total sleep time was somewhat longer but awake time was not appreciably altered. Total REM

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time in minutes decreased, as did REM percentage. Both the average number of REM periods per night and the average length of the REM periods decreased. The latency to REM onset increased significantly. Iproniazid differed from tranylcypromine in that there was little effect noted on the first night of administration. The effect was noted the second night and appeared to be cumulative; the most pronounced changes in REM percent and latency occurred after several days of drug administration.

These results are similar to findings in man. A decrease in catecholamines and serotonin effected by reserpine is accompanied by an increase in paradoxical sleep and a decrease in latency to its onset; increased levels of catecholamines and serotonin are associated with both decreased paradoxical sleep and greatly increased latency, or increased latency alone.

Iproniazid and tranylcypromine exerted somewhat different effects on sleep patterns. Both increased latency to REM onset, but only iproniazid significantly decreased the amount of paradoxical sleep. Tranylcypromine, which is structurally similar to amphetamine, is known to have "amphetamine-like" side effects in clinical usage, in addition to its MAO inhibiting properties. One might speculate that its mode of action might combine catecholamine release from nerve endings with MAO inhibition, the latter taking somewhat longer to become effective due to an active release mechanism taking place concurrently.

These results have implications with respect to depressive syndromes in man. Some investigators have hypothesized that certain depressive disorders are related to a relative deficiency of noradrenalin at functionally important adrenergic receptor sites in the brain, and reserpine has been reported to induce depressive reactions in certain patients treated for hypertension. The depressive symptoms usually disappear when reserpine is discontinued, but occasionally electroconvulsive therapy has been necessary to alleviate the symptoms.

Sleep studies in patients with depressive illnesses have most often disclosed a general disruption of sleep patterns, with less deep (Stage III and IV) sleep, often but not necessarily less paradoxical sleep, frequent awakenings, and more awake time during the night. Several studies, however, have reported occasional psychotically depressed patients that exhibit normal or elevated REM percentages with a decrease in latency to REM onset findings similar to the results reported in the present study after reserpine administration. In certain depressive syndromes and artificial reserpine administration, the sleep patterns may be representative of an underlying deficiency of noradrenalin.

Misconceptions About Female Prostitutes

PAUL H. GEBHARD

It is difficult to define prostitution. Acceptance of money or gifts in exchange for sexual activity is found among mistresses, girlfriends, and wives. Sexual activity with strangers or persons for whom there is no affection occurs among some promiscuous females and among nonpromiscuous females when inebriated or under stress.

An operational definition is: A female prostitute is a female who for immediate cash payment will engage in sexual activity with any person (usually male), known or unknown to her, who meets her minimal requirements as to age, sobriety, cleanliness, race, and health. The statements in this article are based upon the histories of 127 white females who fit this definition.

The prostitute lends herself to folklore and speculation. She may simulate passion or bored acquiescence, she may seem friendly or bitter, and she conceals her private life and feelings. When this variation and obfuscation is perceived in terms of masculine wishful thinking and projection, it is small wonder that misconceptions abound.

The "white slavery" idea has dwindled, but not vanished. Such a tale is a simple way to satisfy an inquisitive client and possibly elicit an extra few dollars. Only 4 percent of our sample were "forced" into prostitution, and even then they were presented with alternatives. The female who says her husband or boyfriend forced her to become a prostitute is saying she chose prostitution rather than lose her mate and possibly experience a beating. Even in brothels the management would not want the problem of confining a captive beseeching her clients for rescue.

Another myth is that of the seduced innocent who felt that with the loss of virginity she was no longer suitable for anything but prostitution. No female in our sample gave this hoary tale.

One not infrequently finds statements that nymphomania gives rise to prostitution. While an occasional promiscuous female may decide to add profit to pleasure, the nymphomania hypothesis is not sustained by factual data.

Since it is difficult to earn by legitimate means sufficient money to support an addiction to morphine or heroin, a number of addicts turn to prostitution. But this etiological factor seems to have been overemphasized; in our sample only 4 percent were ever addicted to "hard" drugs and another 5 percent had experimented with them without becoming addicted. Use of amphetamines and marihuana was more frequent, but their cost is not enough to force one into seeking illegal revenue.

The major motivation for becoming a prostitute is financial. Nine out of ten of our sample listed money as the prime motivation. Second, one can meet a diversity of males, some of them interesting, and one may enter a social milieu otherwise inaccessible. This attractive picture holds true only for the independent prostitute or call girl; a "house-girl" in a lower class brothel processing blue collar clients

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does not enjoy these benefits. However, brothels have become uncommon, so this secondary motivation is progressively more important.

Men hold two contradictory beliefs about prostitutes' feelings toward them. The prostitute is callous, bitter, and hard-hearted—"as cold as a whore's heart." Or men cherish the image of the comradely warmhearted "Irma La Douce."

The truth is that the prostitute's attitude toward her clients is not unlike that of anyone providing services to a diverse clientele. Some clients are disliked, toward most one feels neutral, and a few are liked.

A similar picture is seen when one examines the percentage of acts of prostitution which result in orgasm for the prostitute. Young prostitutes and call girls are more responsive than older women and house-girls. Many prostitutes avoid orgasm, some feeling it is an evidence of affection, while others find it too tiring. Of course, nearly all prostitutes simulate orgasm since this is part of pleasing the client.

The assumption that prostitution must be a distasteful business regretted by those who perform this service is another misconception, for two-thirds of our sample reported no regrets.

Certain clinicians have hypothesized that prostitutes are frigid, some claiming the frigidity caused prostitution while others regard it as the result of prostitution. Actually, in their coitus with friends and husbands the prostitutes are somewhat more responsive in terms of reaching orgasm than other females.

It has been stated that prostitutes are infertile. Our data do not indicate any marked infertility. Some 39 percent had been pregnant by friends and 20 percent by husbands. This brings up the question as to how often prostitutes are impregnated by clients. Only 11 percent reported this occupational hazard and another 4 percent were uncertain as to whether the conception was by a friend, customer, or husband.

In mentioning occupational hazards one is reminded of the belief that venereal disease is inescapable for the prostitute. This belief is substantiated by our data. Two-thirds of our sample had had syphilis or, more commonly, gonorrhea.

Another bit of folklore is that prostitutes accept all sorts of exotic sexual behavior. This is emphatically untrue. While prostitutes set broad limits in their professional sexuality, in private life they express preferences and biases just like anyone else. Unusual behavior is regarded as "freakish," pathological, and something to be avoided in private life.

To the average person prostitution seems incompatible with church attendance and religious adherence. While most prostitutes rarely attend religious services, a substantial minority do so.

The last misconception is that prostitutes are basically homosexual or turn to homosexuality. This is not substantiated by our data. Prostitutes so effectively compartmentalize their lives that their profession does not interfere seriously with their heterosexuality, orgasmic capacities, or ability to form affectional relationships with men.

Psychiatric Disorders Among the Patients of General Practitioners and Internists

BEN Z. LOCKE and ELMER A. GARDNER

How perceptive is the average family physician in detecting mental illness, and what factors influence his perceptiveness? If the family physician is to function as a resource for early detection of mental illness, how must his training be altered? And how would the caseload for all the psychiatric services in a community be affected if the family physician referred all patients in whom he perceived a significant psychiatric problem to a psychiatric service?

Monroe County, N.Y., afforded an opportunity to obtain a partial answer to these questions. A case register of psychiatric services has been maintained since 1960 with almost all services reported since it was started.

Of the 314 internists and general practitioners in the County in 1964, 233 were eligible for the study. Thirty-five percent were invited to participate, and 72 percent of these entered the study. Each physician reported all patients seen during a 1-month period.

The internists reported an average of 176 patients per month, and the general practitioners an average of 304 patients per month. Of the 14,117 patients seen, 2,003 were diagnosed as having a mental or emotional disorder —hereafter designated as a psychiatric problem. Both groups showed similar rates of psychiatric problems among their patients. Our report will concentrate on 11,144 white patients, 15 years old or older, of whom 1,879 (16.9 percent) had psychiatric problems.

Condensed with permission from *Public Health Reports*, 84(2):167–174, 1969.

Psychiatric problem rates rise with age, reaching a peak in the 35–54 age group for men and women. Women had higher rates than men: 20.9 percent for women, 11.1 percent for men. Equal rates of psychiatric service for men and women were reported to the psychiatric case register, but the differential may be explained by the large number of men reported to the register from the lower socioeconomic groups and who entered the psychiatric services through legal channels or emergency divisions. In contrast, private psychiatrists in 1964 treated more women than men as new patients —more in line with the practice of family physicians.

Analysis by marital status showed higher rates for separated and divorced women than for married women; the men in these categories had rates similar to those for men in the single and married categories. In contrast, the rates for cases reported to the register were considerably higher for separated and divorced than for married men.

Patients with one or more visits during the previous year had higher rates than the patients with no visits during the previous 12 months.

The patients under care for 6–12 months had the highest psychiatric problem rates. Low rates for patients, especially men, known to the physicians for a period of less than 6 months, and higher rates for patients with multiple visits during the previous year indicate that the physicians are better able to detect emotional illness with a developing relationship, repeated visits by the patient raise the suspicion of emotional factors, and

persons with a purely physical disorder tend to be terminated earlier, leaving a greater proportion of patients with emotional disorders.

When medical diagnostic categories were correlated with psychiatric problems, the highest rates were among the patients with ailments of the digestive system and symptoms of senility or ill-defined conditions. Women with ailments of the genitourinary system, nervous system and sense organs, and circulatory system also had high psychiatric problem rates. The high rate of psychiatric problems for patients with digestive system disorders could result from a true association between the disorders of this system and emotional problems or could stem from the popular belief about a relationship, thus affecting the perceptiveness of the physician.

Physicians reported that three-fourths of the patients 15–64 years old were aware of their psychiatric condition, but only 56 percent of those 65 and over recognized their condition. About 17.5 percent of the patients with psychiatric problems had recovered from a previous psychiatric condition, and 21 percent of these patients had previously received or were receiving specific care. The length of time a patient had a problem appears to be related to whether or not he had received specific care. Only 11 percent of the patients bothered less than one year had received care for their condition as compared with 32 percent who had been bothered for 5 years or more. These data suggest that patients with emotional disorders remain under the physician's care longer than those with purely physical disorders, and may indicate the need of earlier referral for psychiatric care.

The physicians were asked whether the psychiatric problem of a patient represented a primary psychiatric disorder or a transient adjustment reaction to a medical or nonmedical problem. They reported that two of three patients had a primary psychiatric disorder. Almost 80 percent of the patients with a primary psychiatric problem received a diagnosis of psychoneurotic disorder or personality disorder.

Only 8 percent of the patients were diagnosed as psychotic as compared with 27 percent reported as psychotic in private psychiatric practice. Since it is our impression that many patients are referred to private psychiatric care by other medical practitioners, apparently some sorting-out of psychotic patients is done in the referral process. We have been speaking of rates or percentages; in actual numbers, the nonpsychiatric physicians see more psychotic patients than psychiatrists see in private practice.

Of the estimated number of persons seen in 1 year, the physicians thought that 11,500 of the adult white population would have psychiatric disorders, and that approximately 6,900 would have moderate to severe impairment from these disorders. Thus if family physicians acted as a source of early case detection and referred to a psychiatric service all new patients that they judged had a significant psychiatric disorder with moderate to severe impairment, the total psychiatric caseload would be doubled.

Nonverbal Leakage and Clues to Deception

PAUL EKMAN and WALLACE V. FRIESEN

We will consider two forms of deception: alter-deception, where ego, (ego is used to refer to the party of principal interest in a dyad, not in the psychoanalytic sense) the deceiver, conceals information from the other interactant, alter; self-deception, where ego is the object of his own deception, concealing information from himself. Alter is not deceived if he perceives deception clues or leakage. Deception clues tip him off that deception is in progress but do not reveal the information; the betrayal of that information we call leakage. During alter-deception, if ego realizes alter is on to him, he may give up his deception; or he may continue it, since acknowledgment of engaging in deception may be more embarrassing than maintaining a deception. During self-deception, alter may be aware of deception clues and leakage of which ego is oblivious; if ego becomes aware of his own deception he may have a feeling that something is amiss, or that he has some conflicting feelings; presumably ego does not become aware of his own leakage during self-deception because to learn the information he has concealed from himself would produce severe anxiety.

The term "blocking" would be applied to those self-deceptive situations in which ego realizes that he has concealed something from himself, or that he can't remember something, or that he can't describe or be sure of how he feels. The terms "repression" or "dissociation" would refer to a more complete manifestation of self-deception, where ego is totally unaware that part of his self has engaged in concealing information from the self-aware part.

Condensed with permission from *Psychiatry*, 32(1):88–106, 1969.

Dimensions of Deceptive Situations

Saliency refers to the degree to which deception is a focus of conscious concern by ego and/or alter. Bargaining, between labor and management or between unfriendly world powers, is an example of symmetrical saliency. Both ego and alter are vigilant about the possibility of deception.

The second dimension is the number of roles adopted by each participant. Both parties may adopt the roles of deceiver and detector.

Collaboration or antagonism refers to the pact between alter and ego about the discovery or maintenance of deception. In a jury situation there is antagonism; ego, the prisoner, wishes to maintain deception, but realizes that alter, the jury, wishes to uncover deception. An example of collaboration would be a philandering husband and a wife who doesn't wish to confront his infidelities.

There can also be collaboration to discover deception rather than to maintain it. Psychotherapy is probably such a situation.

Sending Capacity, External Feedback, and Internal Feedback

The sending capacity of a part of the body can be measured by three indexes: average transmission time, number of discriminable stimulus patterns which can be emitted, and visibility. The face is the best sender, the feet/legs the worst.

External feedback from alter parallels these differences in sending capac-

ity. External feedback can be defined as behavior by alter which ego is likely to perceive as reactive to his own nonverbal behavior. The most external feedback is provided for the face. There is less directed at the hands, and very little to the feet/legs.

We do not mean that alter will not see hand movements or leg/foot movements. "External feedback" refers to those behaviors of alter which provide information to ego that ego's nonverbal behavior is the subject of alter's scrutiny and evaluation.

Internal feedback parallels both sending capacity and external feedback in terms of the differences among face, hands, and feet. People have the greatest internal feedback about their face, next about their hands, and least about their legs and feet.

A last consideration relates to the neuroanatomical properties of the face, hands, and legs/feet. Internal feedback may be more developed and accentuated for the face than for hand and legs/feet because of the relative rapidity of facial muscular movements, and because of the possible neural linkage of the facial muscles as affect programs. Ego may have to monitor facial behaviors very closely because they are such a fast system, capable of being ennervated by involuntary as well as voluntary events.

Our hypotheses about the nonverbal sources for leakage and deception clues can be derived from what has been outlined about sending capacity, internal feedback, and external feedback. Ego will not expend effort inhibiting or dissimulating with areas of the body ignored by alter. Ego cannot inhibit or dissimulate actions in areas of the body about which he has learned to disregard internal feedback or in which he receives little internal feedback.

Leakage and Deception Clues

The face is likely to be the major nonverbal liar, maximally redundant with the verbal behavior during deception, subject to lies of both omission and commission. The chief exceptions are micro facial displays, which can serve as leakage or deception clues. Because the face is such a fast sending system, even during alter-deception there may be affect displays which begin to emerge before ego is fully aware of them and can squelch them.

The hands are easier to inhibit than the face. But the hands, unlike the face, are not fakers; most people will not use their hands to dissimulate. The hands commit lies of omission but not of commission. Major forms of leakage in the hands are the adaptors, particularly the self-adaptors. While facially smiling and pleasant, ego may be tearing at a fingernail, digging into his cheek, protectively holding his knees, etc. Self-adaptors can also serve as deception clues, betraying discomfort about the deception.

Leakage in the legs/feet could include aggressive foot kicks, flirtatious leg displays, autoerotic or soothing leg squeezing, abortive restless flight movements. Deception clues can be seen in tense leg positions, frequent shift of leg posture, and in restless or repetitive leg and foot acts.

We have conducted experiments employing records of natural occurrences of deception.

The design was to show a silent film of interviews to two groups of observers, one group viewing only the face and head, the other viewing the body from the neck down. The observers were not told they were seeing a psychiatric patient. Both groups described their impressions by checking words from an adjective check list, descriptive of attitudes,

traits, affects, manners. To test hypotheses about the source of leakage of withheld information, the information conveyed by head/face cues was contrasted with information conveyed by body cues.

The studies show a difference in the information conveyed by the head as compared to the hands/legs/feet, which is in the direction predicted by our formulation of leakage and deception clues. There are some exceptions. Some people do not leak very much, if at all; they are professional, convincing nonverbal liars—for example, the professional dancer or actor, the skilled courtroom lawyer, the shrewd diplomat or negotiator, and the successful used-car salesman.

If one considers why a person does not succeed in deception, one finds three explanations. The simplest is that the person has a conscious wish to be caught. In such cases, the concealed information would be conveyed by macro facial displays, postural cues, and other easily and usually attended to forms of nonverbal behavior.

The second explanation is that he may feel secondary guilt, shame, and/or anxiety about engaging in deception or the possibility of being discovered, and these feelings add to his problem of concealing information.

The last explanation is that ego cannot monitor and disguise those forms of nonverbal behavior to which he has customarily not attended and about which he does not maintain feedback; and, if he has learned that most people do not usually watch certain types of activities, then he does not bother trying to inhibit or dissimulate in regard to those activities.

There are a number of applications of leakage and deception clues. People could be trained to become better nonverbal liars; the most benevolent use of such procedures would be in the dramatic arts.

We have suggested types of behaviors for which the diagnostician or clinician should look; these may be useful either in evaluation or as a focus in bringing problems to the attention of the patient. Training could be developed which would improve recognition of micro expressions as well as alert the observer to particular nonverbal acts. Knowledge of nonverbal leakage and deception clues could be utilized to develop lie detection procedures which rely upon nonverbal behavior.

Our formulation of the origin of leakage and deception clues suggests that the phenomenon may change—and partially disappear—as attention is brought to bear upon it. If the reader believes what has been said, then when he is engaged in deceptive situations he may monitor his own behavior more closely, and be more alert about what to inhibit and which body areas to scrutinize. In the role of alter he should be more attentive to the areas of leakage in others.

Training for the Campus Ministry

The Rev. Henri J. M. Nouwen

During World War II, chaplains were faced with a difficult question: How to be a pastor without a Church? Perhaps our campuses today are like the battlefield of World War II.

In the midst of this confusion ministers grope for training. If the role of the minister is delineated, the areas for training are laid bare. How can the priest be an efficient and skillful pastor in a campus community? How can he remain a whole and integrated man in a milieu which is constantly changing and by its own nature challenging his own commitment? The second question is more important than the first. Finally, what is the best way to prepare a man for this ministerial task?

The main concern of the efficient and skillful campus minister is the student, even though faculty and other personnel ask for attention.

For most students, life was well defined during their high school years. At college, things became different. Familiar answers do not work, cherished beliefs lose their obviousness, and carefully built structures crumble, sometimes suddenly, sometimes gradually. In this milieu, the question mark becomes the most respected symbol. Do I have anything to hope for? Is love a real human possibility? Is there anyone who cares for anyone except himself? Is life worth living?

It is in this milieu that the campus priest has to be a pastor. Perhaps the desire of many students is to find a climate in which they are allowed to ask questions without fear. Most amazing about many Christian milieux is the taboo on asking questions. The most common form of mental suffering on campuses is depression. "Why do I live?" is turned into a castigating self-doubt, "Is it worthwhile to live?"

Can the priest tolerate this question? Can he offer a climate in which the most basic doubts can be expressed, the most sacred realities unveiled, where despair can be allowed to be despair without the need to fill the threatening holes?

The first demand of a question is not to be answered but to be accepted. Then the problem of faith can become the mystery of faith, and the problem of God the mystery of God. As long as the priest considers atheism as the only alternative for orthodoxy, and unbelief as the only alternative for dogma, every question will be a threat and every doubt an attack calling for defense. But his faith tells him that growth can take place only when belief and unbelief, doubt and faith, hope and despair can exist together.

Diagnosis has been one of the weakest qualities in the pastoral field. What doctor would give all his pills to all his patients? What psychologist would administer all his tests to all his clients? It is sad to see so much pastoral activity based on the supposition that all the good words are good for everyone.

Not everyone needs encouragement, not everyone asks for correction, not everyone is ready to be invited to prayer or to hear the name of God. Some ask for silence, some for a single word, some need instruction, some just understanding, some want a smile, some a severe hand, some need support, and some need to be left alone.

Condensed with permission from *Pastoral Psychology*, 20(192):27–38, 1969.

Perhaps today's anticlericalism on campuses is related to the insensitivity of men whose vocation is to care for the most individual need.

The third and perhaps most difficult thing to offer is a "home" where some degree of intimacy can be experienced. In our modern, highly demanding competitive university, many students suffer intense loneliness. They have their antennas out to pick up all signs to good grades, recommendations, graduate schools, and jobs. For many, it has become a matter of life and death because if you can't carry books, there will be little else than rifles to carry. In this stress-filled situation, intimacy has become impossible. In this searching time of life there is a heightened desire for warmth, tenderness, and disarmed relaxation. How can the minister satisfy this need?

The answer is obvious but immense. It is the creation of a community where the student can experience some sense of belonging. There are many ways in which we have tried to form these communities: discussion groups, weekends, retreats, many forms of celebration, especially the Eucharist. Crucial to all these attempts seems to be the creation of a healthy balance between closeness and distance.

The problem of intimacy is often the core problem of the emotional life of the young adult. His relationships with female and male friends can be clouded by painful anxieties. Closeness is desirable as well as fearful and it asks for a careful guide to find a balance which can lead to a life in which one can be committed and open-minded at the same time.

How can the minister himself become and remain a whole man in a community which is constantly changing and challenging his own commitment? In many ways the campus is the most demanding and tiring place for a minister to work. Every four years his parish is repopulated. Over and over again, he is asked to respond to doubt, aggression, and loneliness and to act as guide to the intensive struggle for self-discovery and meaning in life. For the student, college is a temporary phase; for the minister, it is a way of living. Finally, how much questioning can a man take? Not only the student but also, and perhaps even more, the minister realizes that his own existence is at stake.

A university is not only a place for intellectual pursuits but also for intellectualization, for rational behavior and for rationalization. It is probably not only the most verbal place but also the most wordy and talkative place. In this context the minister needs silence. This is threatening. It is like giving up control over our actions and thoughts, allowing something creative to happen not by us but to us. Silence is that moment in which we not only stop the discussion with others but also the inner discussions with ourselves. Without silence we will lose our center and become victims of the many who demand our attention.

The second need is friendship. Here we enter a difficult area because it is most sensitive. If the student community becomes the main source of the priest's gratification and satisfaction, he becomes the victim of fluctuating sympathies and preferences and loses his freedom. The campus minister needs privacy, a home where he is not with students, and where he is free for himself. Only then can he keep from drowning in the fluctuating life of the university.

Besides silence and friendship, insight is one of the main constituents of the spirituality of the campus min-

ister. By "insight" we mean the minister's sound perspective on the significance of his own priesthood. If the minister thinks that *he* is responsible for faith on campus—that it is his task to bring as many students as possible to the sacraments, and that the students' way to heaven is related to their membership in the Church—the campus is going to be his purgatory.

There are many settings within which we can envision a training situation: a one-day-a-week program extending over a whole year, series of intensive workshops, full-time summer program, and, ideally, a year of pastoral internship. Programs of this nature should be planned on the campuses. If this is not possible, other training fields such as general and mental hospitals, educational centers, prisons, and industrial schools could be considered. But essential for every setting is that it offers supervised pastoral experience. Experience without supervision can lead to the adaptation of poor patterns of behavior which are very difficult to shake off.

The most striking characteristic of supervision is the constant invitation to take back our projections. The center of attention is the trainee. Although the trainee might explain his difficulties in terms of the problems of his older pastor, the rigid institution, the unfatherly bishop, the anticlericalism of the students, the supervisor will ask him, "But what about you?"

Secondly, supervision is a school for alternatives. Every pastor has his own strengths and qualities. Professional training means training which broadens our modes of shepherding and offers us possible alternatives. It gives us the freedom to act differently in different situations based not just on our inclination but on the understanding of the particular situation. Through supervision we are invited to face the weaker aspects of our behavior.

Finally, supervision is the way to ask the basic questions. Supervision is not a problem-solving device in which the supervisor advises his student what to do in difficult cases. Instead it offers the freedom and opportunity to ask the basic question.

But what has to be supervised? The answer seems simple: Pastoral experience. But how does pastoral experience become available for supervision? By control, by creative limitation. Psychotherapy has been called: "A controlled life experience." Training for the ministry can be called: "A controlled pastoral experience."

This article also appears as a chapter in a book: Nouwen, Henri J. M. *Intimacy—Pastoral Psychological Essays.* Notre Dame, Ind.: Fides, Inc., 1969.

The Rehabilitation Living Unit—A New Resource for the Emotionally Disturbed Student

E. Robert Sinnett

In mental health units at medium-sized and large universities one usually finds mental health professionals offering diagnostic services, brief psychotherapy, chemotherapy, and short-term inpatient care. These units share other characteristics: they are working at full capacity, have a waiting list, and have staff openings. The volume of needed services cannot be provided.

The community mental health movement has had little impact on campus services. In contrast with utilization of the social milieu in psychiatric hospitals and transitional facilities such as halfway houses and rehabilitation centers, the therapeutic and rehabilitation potential of the living unit has been neglected. There has been little use of volunteers as resource persons for the emotionally disturbed student.

The rehabilitation living unit described here is on the campus of Kansas State University. It is housed in a modern dormitory designed for 600 students. The remainder of the dormitory is a women's residence hall. The project is coeducational with approximately equal numbers of men and women. Of the 20–24 students comprising the living unit, there are approximately equal numbers of clients and volunteers. Facilities are identical with those available to other dormitory residents except for two student rooms furnished as a lounge and conference room for the use of project members and invited guests. This space is designated to serve the function of frequent interaction between the members of the living unit.

Staffing patterns are essentially the same as for other university residence halls with one exception. The residence hall director is resident director of the rehabilitation unit. Although no mental health professional is in residence, professional staff are on call should a crisis develop.

An attempt is made to secure normal college students of both sexes as volunteers by asking student personnel workers and faculty to submit names of students whom they feel are relatively mature, interested in community service, and whom fellow students find approachable and friendly. These nominees are interviewed by our clinical staff and selection is based on the interview. No criteria with respect to class, grade-point average, or major have been imposed.

The volunteers fit into two categories as defined by other researchers. They are indigenous nonprofessionals. They are faced with problems similar to those faced by clients, although their problems are generally less severe and typically dealt with more successfully. The volunteers fit into the "existentialist" style in that they receive and often expect to gain as much as they give. They are usually impelled to reflect upon themselves more honestly, and frequently gain in coping ability as a result of helping others deal with problems.

On the whole, they are students with a nonprofessional view of the treatment process. They are encouraged to offer friendship and acceptance and to share their own thoughts

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and feelings with fellow project members on a peer basis. The volunteers do not identify with professionals but with the clients, and see themselves as members of a group with problems to solve.

Each year about 10 percent of the university enrollment seek some type of service from the Counseling Center or the Department of Mental Health. Counselors are asked to nominate clients for this rehabilitation project if they feel they will need more psychological assistance than can be provided by conventional services. The decision as to whether he comes to the living unit is made by the client himself.

The student most commonly nominated has problems involving severe social isolation, loneliness, and complaints of difficulty in establishing and maintaining interpersonal relations. Difficulty with concentration, organization of thought, and sustained intellectual productivity is severe. Depression, manifest anxiety and insomnia are common. Impulsive acting out may also be a part of the configuration.

The degree of severity ranges from moderate to severe. The clients are not as manifestly disturbed or regressed as many patients found in mental hospitals. However, suicidal ideation is common although suicidal attempts have been relatively infrequent.

Clients in the living unit receive the usual services of the university treatment system. All receive counseling or psychotherapy. Consultation from the psychologists on the project staff and medical and psychiatric consultation are available and can also be used by volunteers.

With respect to the social system, students are encouraged to help one another and to be honest, open, and confronting. In addition to providing support, and for some, structure, students are encouraged to deal with immediate problems in group living by feedback and confrontation. The importance of positive regard for the individual during the confrontation process is emphasized. Individual responsibility is an expectation for clients and volunteers alike.

Student helpers have no distinctive dress, status, or title, and there are no socioeconomic differences between groups. Both volunteers and clients have held jobs in the residence hall system in food service, housing, in the mail room, and at the switchboard. Both groups have held offices in residence hall government and have participated in hall social functions. Unlike the staff in usual treatment systems, fellow project members are available evenings, after closing hours, and on weekends.

A weekly project meeting is attended by the entire membership of the living unit plus staff persons. It is presided over by students who take turns being chairmen. Though staff members interact as members of the group and occasionally offer interpretations, they do not provide leadership. The focus is on problems in group living, and the orientation is like that of a T-group wherein students are encouraged in their efforts toward self-understanding and understanding others. The group serves as a self-governing body within the framework of university regulations. Following a meeting of the group as a whole, subgroups, with one staff person in each, have met for free discussion, and human relations exercises have been employed as a structured way in which to get involvement from all members and to provide a stimulus for discussion.

The voluntary self-selection process of entering this project seems to result

in a selected sample of cases. Some students who might benefit decline to enter. Several subgroups, e.g., those who value sexual freedom and like free access to alcoholic beverages, decline. It is rare to find a "hippie" or Bohemian person. A second subgroup is comprised of schizoid, borderline schizophrenic, or schizophrenic individuals who prefer solitude. A third consists of students in fraternities and sororities. There are some individuals, too, who are concerned about possible stigma. In general, however, the project has remained free of an unfavorable reputation. The stigma of being in the project is no greater than that for seeking outpatient psychotherapy or counseling. Less obvious, but a social force, is the obverse of stigma, for which there is no name: it is damaging to the reputation of an obviously troubled person for him *not* to be getting all the help he can.

The living unit program seems suited for the social isolate who is striving to become part of a group. The pull of the group for people to be involved with others changes the content of therapy hours and facilitates progress.

Perhaps the most difficult individual to treat has been the infantile character. Outcomes have been satisfactory, but much staff and volunteer time has been consumed. For the person who is too infantile or disorganized to assume responsibility, a day hospital, rehabilitation center, or inpatient milieu therapy approach might be the treatment of choice.

The living unit appears to offer sufficient structure, support, and confrontation so that, if a student is sufficiently intact intellectually, he can be retained in college. Some subjects who were considered high risks have fared quite well, after a stay of one or two semesters.

Professional staff, faculty, and administration have come to view the unit favorably and as a significant resource for severely disturbed students. Several offspring of faculty and administrative staff have been clients and volunteers.

The research findings are complicated by the fact that those individuals who accept participation are more severely disturbed than the control cases. Subjects who refuse participation as controls or experimentals show a high dropout rate commensurate with that observed in potential nominees identified and studied in years prior to the advent of the living unit. A formal followup study is planned in the 1968–1969 academic year.

Mental Health and Mental Retardation Quackery

Roger D. Freeman

The fields of mental health and retardation are fertile ones for quacks, fringe practitioners, and faddists.

Physical and mental health are intimate areas with much emotional investment, focal points for irrational ideas, feelings, and wishful thinking. The need to believe something that is untrue may have deep roots, quite inaccessible to education and persuasion. There are also those who align themselves against the "Establishment." They may identify with the "out" group, which they feel is being persecuted by an "in" group. This feeling, when not justified by facts, can arise out of prolonged adolescent rebellion against authority, or from a fear of being overwhelmed, forced into submission, poisoned, or mutilated, as seen in those who fear fluoridation, vaccination, and transfusions, or that mental health legislation will lead to thought control. Such persons may be excellent prey for quacks who often emphasize the "naturalness" of their treatment.

The medical and health professions, in my opinion, have been lax in dealing with clearly unethical or shoddy practices of their members. There must, or course, be safeguards against rigid orthodoxy of thought and practice, and there should be a continuing recognition that diversity and controversy are signs of health in our fields.

Each of us probably feels he is an expert when it comes to knowing his own mind and motivations. This sets the field of mental health apart from technical knowledge of physical disorders. People are much less likely to argue about the latter.

A more fundamental question is: How can we define mental health quackery when we cannot define mental health? Controversies in the mental health field are intense and basic; they relate to diagnosis, cause, treatment, and prognosis. There is a movement, led by many behavioral scientists, away from the medical model of mental disorder. This may be a sign of vigor in our field, but it has increased public confusion. If professionals are calling each other names, how can one distinguish the quack?

There is another thorny problem: The rate of spontaneous improvement is quite substantial. Proof of efficacy of treatment becomes extremely difficult without elaborate, prolonged, and expensive studies.

Some quack or fringe treatment may be popular partly because it meets specific individual needs. For example, friendship may be provided through patients brought together by the "therapist," money may be acquired by becoming an "adjunctive therapist" after being "cured," and sexual gratification may be obtained either directly from some "therapists" or from parties arranged by the "therapist."

The team concept has brought multiple medical specialties and health professions together, but most people (including many professionals) do not understand the training, role, competence, and limitations of these different groups. The public confuses psychologists, psychiatrists, psychoanalysts, social workers, psychiatric nurses, and others. The difference between a

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psychiatrist and a physiatrist is even less clear. In some settings all of these may have overlapping roles. This is especially true in work with children.

State licensing laws are often inconsistent or nonexistent. In many areas of the United States an unqualified person can claim to be a psychologist, psychotherapist, or marriage counselor without breaking the law.

The factors conducive to quackery are compounded with children because of the feelings parents have for their progeny, the child's dependence upon the family, and because so many people are involved. If there is such a thing as "psychopathology," where does it reside? Is it "in" the child? In the parent or parents or their relationship? Faulty communication within the family? Is the blame to be placed upon society? Is the behavior the consequence of maladaptive learned responses that the parents have fostered unknowingly? Professional opinions differ widely.

When parents seem to have been partly to blame, they may not find it easy to accept responsibility. A search may begin for a person who will tell them what they want to hear: there is something wrong inside the child—a vitamin deficiency, poor vision or hearing, allergies, low blood sugar, epileptic "equivalents" without seizures, brain damage, peculiar temperament, hereditary lags in development, ambidexterity, poor perceptual-motor integration, intrapsychic conflicts, etc. Any of these factors may be exaggerated or overgeneralized as a cause of most or all behavioral problems in children. Is it any wonder that parents are bewildered?

The natural course of the behavior and developmental disorders of childhood is not well known. We must remember that the child presents no steady baseline for comparison. Fear of dogs may be benign at one age and abnormal at another. Because of this range of "normal" behavior, almost any article parents read describing a child with so-and-so's syndrome is likely to ring a bell. If our horoscope or fortune cookie seems to apply to us, what the quack says to the parent may seem not too far off the mark.

Many centers have long waiting lists or give parents little to do except return for reevaluations, while in the meantime they helplessly observe their child's disabilities day by day. Such passivity is psychologically intolerable. It frequently leads to a search for the person who will hold out hope of a cure or substantial improvement.

There is no easy definition of a "quack." We would do better to identify characteristics that should increase our "index of suspicion" about a person's activities such as:

Claiming to provide services for which his training and experience are clearly inadequate;

Making excessive claims without good evidence (caution typifies the honest professional);

Unwillingness to consider that his claimed results might be due to factors he has not taken into account;

Claiming (without evidence) that his treatment is more "natural" than others and is not merely "treating symptoms" but rather the basic cause;

Dependence upon articles (by himself or others) in the popular press rather than carefully prepared scientific publications;

Failure to write letters to the editor requesting clarification and toning-down of claims made in lay articles about his treatment that he has not himself written;

Proneness to choose litigation and threats rather than professional debate as a response to criticism.

While some quacks and fringe practitioners cater to those who want a simple answer, an increasing number seem to be adopting elaborate organi-

zations, scientific jargon, admitting some failures, and mixing their methods with generally accepted techniques.

Note that I have not spoken of the profession of the quack, nor have I assumed that he deliberately defrauds his customers. He may have the necessary qualifications and even be highly respected by some in his field (or in some other field); he may or may not be aware of other than humanitarian motives in his activities; his theories may or may not be generally accepted; his practices and techniques may be effective in one area and misapplied to others. Thus, there are quacks inside and outside the medical and health professions.

In assessing the validity of a man's theories and claims, it is absolutely necessary to keep in mind that the efficacy of many, if not most, professional practices and techniques in the mental health, mental retardation, and child development fields has not yet been proved by rigorous scientific tests. While this is no reason to sit on one's hands and do nothing, it does indicate the need for caution and humility in making claims and giving advice.

I wouldn't want you to seek out a quack for advice on quackery, so I provide the following recommendations:

Encourage responsible publicity regarding the results of treatment (not more presentations of miracle cures).

Improve communications among the different professions.

Provide better knowledge of the hazards of misdiagnosis to our colleagues.

Educate the public about the value of sound programs and the nature of professional roles.

Address ourselves to educational programs where susceptibility to health quackery is due largely to ignorance.

Support appropriate licensing requirements for professionals.

Develop programs for retarded and handicapped children that channel parent activity in a rational and constructive direction.

Keep our own professional houses clean by taking appropriate action against unethical colleagues (with due regard to the inherent dangers of orthodoxy).

Have the courage to speak out when we feel people are being unnecessarily hurt, no matter what the consequences.

Realize and demonstrate, by personal example in our work and in the training of young professionals, the importance of human needs and feelings so that a truly helping relationship may be established. Such a relationship is perhaps the best immunization against quackery.

Mental Health and the Law

Recent Cases

Millard v. Harris, No. 21,492, Court of Appeals for the District of Columbia, December, 1968

The appellant sought release from St. Elizabeths Hospital on the grounds that the 1948 Sexual Psychopath Act is unconstitutional and was superseded by the 1964 Hospitalization of the Mentally Ill Act. He also challenged the lower court's finding that he remains a sexual psychopath.

The 1948 Act defines a sexual psychopath as one who is not insane and who is dangerous because of his lack of power to control his sexual impulses. The court interpreted the exclusion of an insane person to be the equivalent of an exclusion of a mentally ill person. Otherwise, many sexual criminals committed under the 1948 Act would be denied the extensive procedural protections afforded the mentally ill under the 1964 Hospitalization Act. The court refused as a matter of law to read these procedural protections into the 1948 Act.

The Court also refused to find that Congress had intended to repeal by implication the 1948 Act and that the Act is so meaningless and self-contradictory as to be unconstitutional.

To justify the preventive detention of Millard, however, the court said the Government must show that there is sufficient likelihood of sexual misconduct that will present a danger to others. The lower court's finding that Millard's mental disorder did present a danger to others was held insufficient because it did not distinguish between nonsexual and sexual misconduct. The only sexual misconduct he would be likely to commit was exhibitionism, which, according to the evidence, could cause serious psychological harm only to unusually sensitive adult women and to small children repeatedly exposed to such behavior. In the former case the court held it beyond the duty of the law to "sweep the streets clear of all possible sources of occasional distress to such women" and in the latter case, it held that "the likelihood of serious injury to a child happening to see the appellant expose himself in public is too remote to justify commitment."

Mayock v. Martin, Conn. Sup. Ct., 8/6/68, 37 L.W. 2115

The plaintiff asserted that he had a First Amendment right to release from the mental hospital in order to "better express his divine message." He admitted that either in response to a revelation from the Lord or as a free will offering, he would cut off his foot. Twenty years earlier he had put out an eye and cut off a foot, but he said that now he has no such plans.

The court noted that the statutory definition of a mentally ill person includes one who requires treatment for his own welfare. On the basis of this and the psychiatrist's findings that there is a possibility that the patient may harm himself, the court denied the plea for release. The constitutional right of freedom of religion, the court said, does not make an individual's conduct immune from regulation for the protection of society or of himself.

The one dissenting judge noted that the psychiatrist found that "the plaintiff is not dangerous to anyone but himself, and the latter danger is not

a definite thing, in that it is only a possibility in the plaintiff's mind." He concluded: "as between the possibility that the plaintiff may amputate his foot and the certainty that, under this judgment, he must remain incarcerated against his will indefinitely, I choose the former."

U.S. v. Driscoll, Court of Appeals, 2nd Circuit, 8/68, 37 L.W. 2117

The defendant, who pleaded not guilty by reason of insanity to charges of tax evasion, submitted to a court-ordered psychiatric examination of his competence to stand trial. On the basis of this examination, the psychiatrist testified that the defendant was sane when the alleged offenses were committed.

The Court of Appeals found that the admission of this testimony in the lower court was unwarranted and reversed the conviction on the ground that the defendant was not advised that the psychiatric examination could be used to refute his claim that he was insane at the time of the alleged offenses rather than merely to establish competency. Had he been given such notice, he might have asked for and perhaps received, with or without the government's consent, such procedural safeguards as his own counsel at the examination or a transcript or video tape of the proceedings. Most important, notice would have enabled the defendant to consult with counsel beforehand so that he could fully and intelligently respond to the doctor's questions.

One judge dissented from the majority on the grounds that the lack of counsel before the examination was not shown to have prejudiced the defendant and that the defense has no right to either an examination transcript or to the presence of counsel during the examination.

Watson v. United States, U.S. Court of Appeals for the District of Columbia, Nos. 21,858 and 21,860, February 5, 1969.

The appellant challenged the legality of her commitment under Title II of the Narcotic Addict Rehabilitation Act of 1966. When she had appeared for sentencing for housebreaking and uttering (presenting a forged instrument), she requested and the court granted preliminary commitment for examination under the NARA. After it was reported from the NIMH Clinical Research Center that she was treatable, she announced that she no longer wanted to be committed because she did not want to be so far from her children for so long. The court ordered her committed anyway. She appealed for revocation of the order and remand for sentencing, arguing that the court could not commit her over her objection and that she was not an "eligible offender" within the meaning of the Act.

The court rejected the first argument, noting that Title II makes no provision for a defendant to elect between commitment and regular sentencing. "If after examination the court finds him addicted and treatable, and provided appropriate facilities are available, Section 4253a says the court shall commit him for treatment." The court left open the two questions of whether there are limits to the court's discretion to refuse an eligible offender's request for post-conviction commitment or whether a court may ever honor an objection to commitment once an eligible offender has been found treatable.

The appellant argued she is not an "eligible offender" because among

other reasons the definition of such excludes from Title II's coverage "an offender against whom is pending a prior charge of a felony which has not been fully determined." After appellant had been committed, the court had dismissed several additional felony counts against her. The court rejected as splitting hairs her argument that the felony charges had to have been dismissed before rather than immediately after the order for commitment. The more substantial argument that Congress had intended to exclude offenders who have undetermined charges pending at the time of either their conviction or the dispositional proceeding, the court rejected on the basis of the House Committee report on the Act which indicated that having a "pending felony charge is an absolute bar to eligibility unless the court dismisses the charges."

Ortega v. Rasnor, etc.—291 F. Supp. 748, U.S.D.C., S.D. Fla., October 15, 1968.

The petitioner originally had filed a petition pursuant to Title III of the Narcotic Addict Rehabilitation Act of 1966 to be committed for treatment for narcotic addiction. After a hearing, he was committed to the custody of the Surgeon General for confinement at the Clinical Research Center at Lexington, Kentucky for examination. He was found to be addicted and rehabilitable, and he waived his right to a further hearing. The court then committed him for rehabilitation and treatment, and petitioner remained at the hospital. Subsequently, he sought to withdraw and filed a writ of habeas corpus with the court. One of the grounds he gave for release raised the question of the constitutionality of Title III of NARA.

The court denied his writ. This was not a situation of compulsory treatment, it said, since the petitioner instituted the proceedings for his civil commitment of his own violation. The court dismissed the petitioner's assertion that Congress does not have the power to prescribe a course of medical treatment for a citizen it will never see. It said "It cannot be seriously disputed that a proper exercise of the police power underlies the promulgation of Title III of the Narcotic Addict Rehabilitation Act of 1966.... The power of the Congress . . . to promulgate laws for the betterment of the public health, morals, safety and welfare is beyond question."

Marable v. Alabama Mental Health Board —U.S.D.C., M.D. Alabama, February 11, 1969 (37 L.W. 2492)

Plaintiffs, patients in certain Alabama State mental institutions, brought a class action charging unconstitutional racial segregation of inmates and employees in State mental institutions. The defendant, the Alabama Mental Health Board, challenged the plaintiffs' standing to sue on two counts: first, that plaintiffs could only challenge segregation at those institutions at which they personally were patients; secondly, that plaintiffs were not entitled to raise the issue of discrimination in employment practices. The Court found for plaintiffs on both counts. It stated that "it is . . . [not] necessary for Plaintiffs to be confined in every facility administered by the Mental Health Board," as long as the suit is "brought by a person (or a class) who is a proper party to request an adjudication of a particular issue."

As to the second defense, the court held that, while plaintiffs, as potential employees, did not have standing to challenge the practices, they did, as patients, have such standing, because

of the secondary effects on patients of discrimination against staff personnel.

Having found the suit to be properly brought, the court held that "the segregation and discrimination based on race practiced by Alabama officials in the mental health system violate the rights of plaintiff . . . and his class under the Equal Protection Clause of the Fourteenth Amendment." The court further held that "the discrimination in employment practices is unconstitutional."

By way of dictum, the court distinguished the action it took in the instant case from any action it might take if the classification were a reasonable one: ". . .this decree should not be construed as precluding officials from making in good faith and in particularized circumstances, medical discriminations which take racial factors, such as patients' fears and delusions into account. Racial classifications are always suspect, however, and if such actions are challenged, the burden will be on the officials to demonstrate that the discrimination is medically justified."

The digests of recent cases are based on material prepared by the Legislative Services Branch, Office of Program Planning and Evaluation, NIMH.

Mental Health News Digests

Clinical Psychology and Public Practice

A new doctoral training program will be started this fall at Harvard University. It will lead to a degree in Clinical Psychology and Public Practice. Training and research will be provided by the faculties in medicine, arts and sciences, divinity, and education. The program is designed to improve work in the mental health field, particularly work with population groups that are now not served adequately. Several different settings —hospitals, courts, family planning centers, community and child guidance centers—will be used in the training program. The hope is that the new program will result in the development of professional personnel who will develop new techniques in education, psychology, and intervention and prevention in mental health.

The PTA and Mental Health

A project to help communities strengthen their resources for emotionally disturbed children has been launched by the National Congress of Parents and Teachers. Local PTAs will examine their schools' programs concerning children's emotional needs and problems. They will also survey preventive services and make recommendations for expanding them.

Community action teams from the State and local PTAs will work with various agencies and with leaders from the mental health professions during the project, and will present their findings to local decision-makers.

Training Subprofessional Workers

A program to train so-called subprofessional mental health workers has been started by the Massachusetts Department of Mental Health.

Instruction will be given in mental health techniques and methods, social sciences, and psychology. Field work will be part of the training experience. Community colleges will participate in the program. The job classifications, as presently planned, will range from mental health aide to mental health technician, depending on level of educational attainment.

The trainees will come from a wide variety of backgrounds and groups, such as housewives with grown children, welfare recipients, elderly persons, school dropouts, etc. State employees also may become trainees as part of the inservice training program.

Dr. George H. Grosser, assistant commissioner for training, planning, and research, is director of the program.

Campus Unrest and Change

A three-year study of unrest and change on university and college campuses throughout the U.S. is now underway. It is being conducted by the American Council on Education and supported by the National Institute of Mental Health.

Some of the questions that the study will attempt to answer are: Just how much unrest and change are actually present in universities and colleges? Are differences in the campus environment related to the extent and intensity of student protest? Are there individual differences among the students who take part, and those who do not take part in student protest? Are the differences in the administrative structure and practices of the uni-

versities related to incidence of student protest?

Some 300 institutions will be sampled, and about 30 of the campuses will be studied in detail through case studies and interviews.

Dr. Alexander W. Astin, director of research for the Council, is Project Director.

Report on "Independent Practitioners Under Medicare"

One section of the "Social Security Amendments of 1967" directed the Secretary of the Department of Health, Education, and Welfare to report to the Congress before January 1, 1969 on the feasibility of including certain other practitioners under the Medicare act as independent practitioners.

The report, which appeared last winter, recommends that "coverage be expanded for services of occupational therapists, clinical psychologists, social workers, and speech pathologists provided in organized agencies, centers, or other programs that are not presently eligible for participation and that meet requirements established by the Secretary and designed to promote maximum coordination, continuity, and quality of care, and to which patients are referred by a physician, who establishes a plan for the patient's total care and retains over-all responsibility for patient management. Reimbursement for services would be to the provider agency, center, or program on the basis of reasonable cost."

The report also recommended that coverage for services of physical therapists remain as established in the 1967 Amendments and that there be no changes in present coverage for services provided by optometrists, audiologists and corrective therapists, chiropractors, or naturopaths.

Mental Health Developments in Delaware

The Psychiatric Emergency Service, part of the Southern New Castle Community Mental Health Center, provides complete psychiatric aid through a combination of services—a telephone answering system, walk-in clinic, consultation service for individuals and agencies, and a home-visitation team. It has also produced a series of mental health seminars.

The Emergency Service set five goals, all of which have been met with a staff of three professional and five nonprofessional workers and thirteen part-time volunteers: promptness, prevention of hospitalization, early diagnosis, family involvement, and involvement of other community services.

During the first year the Service evaluated and treated 345 patients. The number of patients from Southern New Castle County admitted to the Delaware State Hospital has decreased by 14 percent since the Service was started.

A series of monthly mental health workshops for school counselors and nurses was begun last fall, cosponsored by the Mental Health Association. The workshops are designed for counselors and school nurses who often are directly involved in special problem cases and yet are not thoroughly trained in how to handle them. The sessions, therefore, explore such areas as drugs and drug users, students or their families under psychiatric care, students formerly in detention institutions, racial problems involving mental health of the students.

Drug Abuse Information

An intensive drug abuse information program has been launched by the National Institute of Mental Health. A Washington metropolitan area tele-

vision and radio campaign was the first phase of an all-media national effort.

Nation-wide advertising began in April, dealing with the dangers of LSD, amphetamines, barbiturates, narcotics, and general drug abuse. The commercials also stress the legal penalties for possession and use of marihuana.

The advertising will be supplemented by a national grass-roots educational program.

A variety of materials are already in mass circulation, including a three-part film series, "The Distant Drummer," two parts of which have already been aired in several major outlets during prime TV time. The Institute has also prepared and distributed nearly 2 million copies of four question-and-answer flyers on narcotics, LSD, marihuana, and barbiturates and amphetamines.

Radio and TV public service messages, newspaper, magazine and billboard advertisements, posters, and bus and subway cards set the general tone. The primary aim is to arm young people with facts to help them resist pressures to experiment with drugs. The campaign is divided into several segments directed at divergent audiences—youths who are experimenting with marihuana and LSD; parents; adults who overuse amphetamines and barbiturates; and ghetto dwellers exposed daily to the dangers of heroin addiction.

The mass education/information program represents an all-out drive which will include such activities as regional press conferences and workshops for high school newspaper editors; curriculum development and teacher training workshops; exhibits at schools and State fairs; mass distribution of factual literature and films; and a national school poster contest.

The advertising, produced by the Grey Advertising Agency of New York City, has earned endorsement from the Advertising Council and will be presented with the cooperation of the media.

The NIMH will support the campaign with free copies of up-to-date booklets on drug abuse to be sent to all persons writing for more information to the National Institute of Mental Health, Box 1080, Washington, D.C. 20013.

Psychologists for Social Action

A new association was formed last fall during the meetings of the American Psychological Association. Named the American Psychologists for Social Action, it is designed to enable psychologists to take action on many social issues such as "militarism, racism, and poverty." Membership is made up of individuals and local groups throughout the country.

Fifth World Congress of Psychiatry

The Fifth World Congress of Psychiatry will be held in Mexico City from November 28-December 4, 1971. Further details will be available from the World Psychiatric Association Secretariat, The Maudsley Hospital, Denmark Hill, London, S.E. 5, England.

Caribbean Psychiatric Association

The Caribbean Psychiatric Association was recently formed. Its objects and purposes are "the cultivation of science in relation to psychiatric disease and the improvement in the treatment of persons suffering from mental and nervous disorders, to facilitate the exchange of information and

ideas on those subjects among the members of the association, to collaborate with other organizations in the field of mental health in the Caribbean." Professor M. Beaubrun has been elected president and Dr. Frank Knight, secretary. On May 10–14, 1969 the Association held a joint meeting in Ocho Rios, Jamaica, with the American Psychiatric Association, on "Transcultural Psychiatry—A Visit to the Caribbean."

☆ U. S. GOVERNMENT PRINTING OFFICE : 1969 347-088/7

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